

The Availability, Accessibility, and Provision of Post-Abortion Support Services in Ontario

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Abstract

In a study we conducted with Ontarian women about their abortion experiences (OAS), one third of participants expressed a desire for post-abortion support. Yet, there is some anecdotal evidence to suggest that organizations offering these services are using judgmental frameworks. In order to rigorously investigate this, we explored what post-abortion support services are offered across the province of Ontario. This multi-methods study included an analysis of OAS data, creating a directory of post-abortion support services in the province, conducting an analysis of how these services represent themselves online, and carrying out mystery client interactions. We found that the majority of organizations offering post-abortion support services in Ontario are crisis pregnancy centers. The services offered at these organizations are built upon frameworks that are both shaming and stigmatizing of abortion experiences. Efforts to increase the online visibility and overall accessibility of non-judgmental, medically accurate post-abortion support services in Ontario appear warranted.

D'après une étude réalisée chez des femmes de la province de l'Ontario par rapport à leur expérience d'avortement (OAS), un tiers des participantes désirent de recevoir du support post-avortement. Des évidences anecdotiques soulèvent que les organisations offrant des services post-avortement ont un cadre de pratique fondé sur un jugement. De manière à examiner rigoureusement cette tendance, nous avons étudié quels sont les services post-avortement offerts à travers la province de l'Ontario. En utilisant plus d'une méthodes de recherche qui incluent d'une part l'analyse des données d'OAS, la création d'un annuaire des services actuellement offerts dans la province, l'analyse de la façon dont ces services se représentent sur la plateforme en ligne et d'une seconde en effectuant des interactions sous forme de clients mystères. Nos résultats démontrent que la majorité des organisations offrant du soutien post-avortement en Ontario sont des centres de grossesse d'urgence. Les services offerts dans lesdites organisations sont basées sur des sentiments soutenant la honte et la stigmatisation de l'avortement vécu. Une meilleure visibilité en ligne et une accessibilité généralement basé sur un cadre neutre et médicalement juste des services post-avortement en Ontario devraient être garantis.

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List of Acronyms and Abbreviations

APA	American Psychological Association
BC	British Columbia
CAPSS	Canadian Association of Pregnancy Support Services
CPC	Crisis pregnancy center
LGBTQ	Lesbian, Gay, Bisexual, Trans* and Queer
NCS	National Comorbidity Survey
OAS	Ontario Abortion Study
PHU	Public Health Unit
PI	Principal Investigator
REB	Research Ethics Board
RJ	Reproductive justice

Chapter 1: Introduction

1.1 Background

Since its decriminalization in Canada in 1988, the physical safety of first trimester abortion performed by trained health professionals has been established and consistently documented (1, 2). Despite the fact that in 1989, the then US Surgeon General, C. Everett Koop, testified that the psychological risks following an abortion are considered “miniscule” from a public health perspective (3), in the public domain, there is frequently a discussion of “post abortion syndrome,” “abortion trauma syndrome,” or “post abortion stress” (4, 5). These are described as “a type of post-traumatic stress disorder ... [that] occurs when a woman is unable to work through her emotional responses due to the trauma of an abortion,” (6). The symptoms of these purported “syndromes” are typically listed as

... recurrent and intrusive thoughts about the abortion or aborted child, flashbacks in which the woman momentarily re-experiences an aspect of the abortion experience, nightmares about the abortion or child, or anniversary reactions of intense grief or depression on the due date of the aborted pregnancy or the anniversary date of the abortion (7).

There is no evidence to support the existence of such “syndromes” and the majority of existing research does not support any association between abortion and subsequent negative mental health outcomes.

Indeed, the bulk of studies that have asserted a relationship between abortion and mental health problems have been revealed to contain major methodological errors. Prominently, in an investigation using data from the National Comorbidity Survey (NCS), Coleman and colleagues reported that women who had an abortion were at an increased risk for mood, anxiety, and substance abuse disorders (8). Upon closer investigation of the statistical analyses employed, concerns were raised by several different researchers about the appropriateness of the analyses.

Other scholars attempted to replicate the results of this paper, but were unable to do so (9). Coleman et al. then published a corrigendum and acknowledged that they had used incorrect weights in the analysis; they also reported the results of their analysis re-run with the correct weights (10). However, other scholars have been vocal that the weight correction was not the only problem with the analysis, and further contend that the published corrigendum is insufficient (11). As noted by Steinberg and Finer, “Once the problem of incorrect weighting is resolved, a more serious problem becomes evident, involving untrue statements about the nature of dependent variables and associated false claims about the implications of the findings” (11, p407).

Following the publicized critique of the paper using data from the NCS, one of the authors of the disputed study, Priscilla Coleman, went on to publish a meta-analysis investigating the literature that examined abortion and subsequent mental health issues (12). The results of this quantitative synthesis suggested that women who had an abortion “experienced an 81% increased risk of mental health problems” (12, p180). These findings directly contrast with a review by the Royal College of Psychiatrists which found that in comparison to the delivery of an unintended pregnancy, abortion is not associated with an increased risk of mental health problems (13). Several authors and scholars have raised concerns about Coleman’s meta-analysis and have highlighted major methodological flaws that they argue nullify the reported results (14-16).

Beyond these critiques of Coleman’s work, many of the studies that were included in the meta-analysis have been criticized individually. Major and colleagues conducted an evaluation of empirical research addressing the relationship between induced abortion and women’s mental health (17). They found that major methodological problems were pervasive in most of the

current literature on the topic, and conclude that “The most rigorous studies indicated that within the United States, the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy is no greater than the risk among women who deliver an unwanted pregnancy” (17, p863). This is consistent with another meta-analysis conducted by Robinson and colleagues (18) which asserted that those studies proposing a causal connection between abortion and subsequent mental disorders were marked by methodological problems. Some of these errors included: “poor sample and comparison group selection; inadequate conceptualization and control of relevant variables; poor quality and lack of clinical significance of outcome measures; inappropriateness of statistical analyses; and, errors of interpretation, including misattribution of causal effects” (18, p268). The authors concluded that “The most consistent predictors of mental disorders after abortion remains pre-existing disorders, which, in turn, are strongly associated with exposure to sexual violence and intimate violence” (18, p268).

The findings of the reviews conducted by both Major (17) and Robinson (18) are consistent with statements issued by a selection of normative bodies, which notably includes the Royal College of Obstetricians and Gynaecologists (19), the American Congress of Obstetricians and Gynecologists (20), and the American Psychological Association (APA) (21). In 2008, the APA formed a task force on mental health and abortion to inspect the available scientific research addressing mental health factors associated with abortion. The report concluded with three main findings: 1) there is no credible evidence that a single abortion of an unwanted pregnancy causes mental health problems for adult women; 2) more research is needed in order to explore other factors that, in conjunction with pregnancy, may place women at an increased risk of developing mental health problems; and, 3) many of the studies published on this topic

suffer from serious methodological problems (21). Finally, neither the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) which is published by the American Psychiatric Association, nor the *International Statistical Classification of Diseases and Related Health Problems* (ICD) which is published by the World Health Organization, recognize the existence of an “abortion trauma syndrome” or “post-abortion depression and psychoses” (22, 23).

Despite the fact that there is no rigorous, empirical evidence to support either the existence of these syndromes or negative mental health outcomes following an abortion in general, this rhetoric is still pervasive. In recent years, opponents of abortion rights have made repeated attempts to tie abortion to mental health conditions and these claims have been used to justify changes in US public policy (9, 16, 18). There are now laws in a number of states that require physicians to inform patients that abortion will result in an increased risk for depression and suicidal ideation (24).

These laws, which are commonly referred to as “women’s right-to-know laws”, have also been used to impose mandatory information sessions and/or waiting periods for women seeking abortion services across the United States (24). Although this legislation is premised on the ethical tenet of informed consent, the information provided during these state-mandated information sessions has been shown to contain medically inaccurate, out of date, and biased information about abortion (24, 25). A 2006 analysis of abortion-specific counseling materials identified 22 states whose materials contained demonstrably false medical information about the procedure (26). In 19 of these 22 states, the abortion-specific counseling materials included information about the psychological effects of abortion (26). More specifically, in seven of these states, the mandated counseling materials detailed the supposed negative mental health outcomes

from abortion, such as regret, anxiety, depression, drug abuse, suicidal ideation, and “postabortion traumatic stress syndrome” (26).

While these policies are presented to the public as beneficial to women by providing them with time to “think through” their decision, abortion rights advocates have instead argued that legislation imposing mandatory information and waiting periods should be understood as strategies designed to reduce the availability of abortion care (27). Certainly, the provision of inaccurate information about a medical procedure can be seen as a tactic to dissuade women from seeking services rather than to inform them. Further, requiring that women seeking terminations are misinformed with flawed research perpetuates the stigma of abortion. By presenting the abortion procedure itself as the cause of negative emotions and mental health outcomes, the variety of factors that leave women with few opportunities to discuss their experiences fail to be taken into account.

The efforts to pathologize abortion have had a chilling effect such that it has become increasingly difficult to explore the full range women’s experiences after an abortion. Indeed, the most prevalent social narratives about abortion outcomes are typically limited to women experiencing either “regret” or “relief” following a termination (28). In a call for a more nuanced conversation of abortion experiences, Weitz and colleagues conclude that

... women can experience a range of emotions, from sadness to elation and everything in between, and even many emotions simultaneously. Women can regret their abortions just as they can celebrate them. Complex feelings are a normal part of major life decisions, and having strong feelings, even negative ones, does not represent pathology. Women do not need to be protected from their emotional responses to abortion. However, as with any stressful event, some women will have more severe responses; these women need support and access to mental health services (28, p88).

This highlights that it is important to have post-abortion support services available, not because abortion in itself is harmful, but because women can experience a range of emotions and

may require a space to process them. This is consistent with a body of literature that has demonstrated that individuals who are encouraged to disclose emotional reactions to stressful experiences, either by talking or writing, actually exhibit improved physical health when compared to control group participants (29, 30). Related to these findings, Major and Gramzow investigated the cognitive and emotional implications of concealing an abortion experience in a sample of 442 women who were followed over a period of two years (31). Their findings suggested that women who felt stigmatized by abortion were more likely to feel a need to keep it secret from friends and family members. Secrecy was related to increased thought suppression of the abortion, which was in turn associated with more intrusive thoughts about the procedure. Suppression and intrusive thoughts were both associated with increases in psychological distress over time. For those women experiencing intrusive thoughts, disclosure was related with a decrease in distress (31).

Indeed, the literature strongly supports that social factors, such as the decision-making process before the abortion and the process of finding social support afterward, play a large role in emotional outcomes following a termination (32). Other social factors that have been found to be associated with post-abortion outcomes include social disapproval, exposure to anti-abortion picketing and protesters, the loss of a romantic relationship, and emotional conflict surrounding the decision to terminate (21, 31-32).

That post-abortion support services need to be non-judgmental and non-directive is especially important. Major and colleagues assessed links between women's social support, self-efficacy, and adjustment to abortion (33). The authors found that women who perceived high support from friends, family members, and partners had higher self-efficacy for coping. Yet, those women who discussed their abortion with a significant other and perceived that person to

be less than completely supportive of their decision were actually more distressed post-abortion than women who kept their abortion a secret.

In recent years there have been efforts to acknowledge the range of emotions that can stem from the decision to terminate and pregnancy and pluralize women's experiences (28). One of these ways has been through the creation of talklines dedicated to post-abortion support which aim to provide women with a space to process their emotions. Kimport, Perrucci, and Weitz (34) investigated four of these talklines as a form of post-abortion support service in the US. The authors conducted interviews and focus groups with staff members and volunteer counsellors from support talklines that varied in political stance, volume of callers served, and religious or secular orientation. In speaking with these counselors, the findings suggested that the silence and stigma that continue to surround abortion mean women have few spaces and opportunities to discuss their experiences. The counselors were in agreement that women need a space "devoid of politics for processing their experience and emotions over time" (34, p88). The authors found that talklines may be especially beneficial in creating a space for women to process the thoughts and feelings they may experience after a termination. Although the authors also note that some mental health needs remain unmet by these talklines, such as pre-existing mental health issues or experiences with sexual violence, they also determine that they do serve a valuable purpose for the women who call. They conclude that post-abortion support talklines should be more routinely integrated into a holistic approach to abortion care.

1.2 Rationale

The investigation of post-abortion support services is preliminary and to date there is little information on the topic. Further, there is no information that relates specifically to

Canada's largest and most populous province, Ontario. Within the Canadian context, most of the available information about post-abortion support comes from a 2009 report investigating crisis pregnancy centers (CPCs) in British Columbia (BC) (35). "Crisis pregnancy center" is a term used to refer to organizations that are not medical clinics but provide services to women such as free pregnancy tests and options counseling. Across the country, the majority of CPCs are affiliated with a registered charity known as the Canadian Association of Pregnancy Support Services (CAPSS) (36).

In both Canada and the US, CPCs have been frequently criticized as providing false and medically inaccurate information about abortion (37-39). This misinformation is used to discourage women from considering or having a termination. The findings of the 2009 report in BC were congruent with these complaints. An undercover volunteer who spent time and received training at several CPCs across BC found that the counselor training involved an abundance of medically inaccurate and anti-abortion information (35). The report also noted that many CPCs were actively trying to expand their provision of post-abortion support services. Counselor training was based on the framework that "In most women, abortion causes 'post-abortion syndrome', a form of post-traumatic stress that leads to such things as depression, nightmares, and suicidal thoughts" (35, p4). Further, the infiltration revealed that

... counseling techniques are designed to induce guilt and emotional stress in the woman for even considering an abortion. [...] for post-abortion counseling, the counseling technique makes a woman feel guilty for killing her baby, and requires her to personify and mourn her fetus before she can obtain forgiveness from God (35, p3).

Despite the fact that to date no rigorous investigation of post-abortion support services has taken place in Ontario, in a study we conducted that aimed to document women's abortion experiences in the province, we were able to iteratively identify a gap in service provision. When asked about ways that they thought abortion care could be improved in the province, a subset of

participants expressed a desire for non-judgmental post-abortion support following their termination (Chapter 3, this thesis). However, these same participants also noted that they had a hard time finding and accessing such a service.

1.3 Specific objectives

A greater understanding of post-abortion support services and their dynamics will help to advance the discussion of women's abortion experiences, and will also stimulate recommendations for service delivery.

Using a multi-step, multi-methods design, this qualitative study specifically aims to:

- A. Explore what post-abortion support services are offered across the province of Ontario;
- B. Examine how existing post-abortion support services represent themselves with respect to framework and structure through online materials;
- C. Evaluate how accurately post-abortion support services represent themselves; and
- D. Assess the frameworks post-abortion support services use to offer services.

1.4 Thesis structure

This thesis takes the form of “thesis by article” and is divided into six chapters. Chapter 1 provides an introduction to the study with a review of the literature related to mental health and abortion and post-abortion support. The chapter also includes the rationale for the study, a list of specific objectives (including the research questions), an outline of the thesis, and a statement of contribution. Chapter 2 describes the methodology for the study in depth and provides an overview of the Ontario Abortion Study (OAS) which was used to inform this project. This chapter includes information about the methods used in this project, including document analysis

and the mystery client method, as well as the analytic approaches and the conceptual framework that were employed.

Chapters 3, 4, and 5 are original research articles prepared specifically for this thesis. The first article (Chapter 3) centers on an analysis of the Ontario Abortion Study interviews and establishes the motivation and rationale for the study. This article discusses women's desire for post-abortion support in the province and also includes their preferences for service delivery. This article has been submitted to *Women's Health Issues* and conforms to the standards of this peer-reviewed journal.

Chapter 4 consists of the second article that has been prepared for this thesis. This article has been submitted to *Journal of Family Planning and Reproductive Health Care* and discusses Phases 1 and 2 of this project. It includes information about what post-abortion services are available in the Ontario and also contains a qualitative document analysis of these organizations' web presence. This article conforms to the standards of the peer-reviewed journal it was written for.

The third research article written for this thesis can be found in Chapter 5. This article documents 17 mystery client calls that I carried out at a subset of organizations offering post-abortion support in Ontario. The article discusses the underlying assumptions of some counselors that I interacted with and makes suggestions for ways to improve post-abortion support in Ontario. This article has been accepted by *Contraception* and is formatted for this peer reviewed journal.

Finally, the last chapter begins with an integration and triangulation of the results. I also situate these findings in the context of reproductive justice before reflecting on my positionality and role in the research. Next, I discuss the significance and implications, future directions, and

limitations of this study. Finally, the thesis ends with conclusory statements. The complete reference list and appendices can be found at the end of the document.

1.5 Statement of contribution

The Ontario Abortion Study (OAS) was used to inform this study. I served as the Study Coordinator of OAS and my supervisor, Dr. Angel M. Foster, is the Principal Investigator (PI). The 60 interviews that were conducted as a part of OAS were carried out by a team of graduate and undergraduate research assistants that are a part of Dr. Foster's research group. In my role as Study Coordinator, I contributed to recruitment efforts, conducted interviews, and carried out a content and thematic analysis related to post-abortion support.

As the Principal Investigator of this study, I completed this project in partial fulfillment of the requirements of the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. In conjunction with my supervisor, I conceptualized the study design and designed the study instruments. I conducted the primary research for the directory of services offering post-abortion support in Ontario as well as all of the mystery client calls, and carried out data analysis for all components of the project. I also led the drafting of all three manuscripts. My supervisor reviewed and contributed to the qualitative data analysis, contributed to and approved the submitted manuscripts, and supervised me through all components of this project.

Chapter 2: Methods

This chapter begins with a brief description of the Ontario Abortion Study and the analysis that I completed using these data. Next I describe the three phase methodology used to conduct this qualitative study, including: the creation of a directory of post-abortion support services in Ontario, a document analysis of the online web presence of organizations offering post-abortion support in the province, and mystery client interactions at a subset of these organizations. Finally, I discuss the ethical considerations and conceptual framework for this project.

2.1 The Ontario Abortion Study

In 2012-2014, I served as the Study Coordinator of the Ontario Abortion Study. My thesis supervisor is the Principal Investigator and designed this qualitative study to rigorously explore the compounding issues of geography and age on women's access to abortion services across the province.

2.1.1 Data collection

Between 2012 and 2014, we conducted in-depth, open-ended telephone interviews with 60 Anglophone women from across Ontario. All participants had an abortion within five years of the start of the study period and resided in the Greater London, Ottawa, Thunder Bay, Timmins/North Bay, or Toronto areas at the time of their termination. We purposively recruited women from the different geographic regions as well as two different age groups, 18-24 and 25 and above.

The interviews asked participants a series of questions related to their demographic information, background, and reproductive health history, as well as about their general experiences accessing both primary and reproductive health services. Participants were then asked about their abortion experience(s), as well as about their retrospective feelings about both the decision and the experience itself. Finally, participants were asked about ways in which abortion services in Ontario could be improved. Interviews lasted an average of 60 minutes, and with the permission of participants, we audio-recorded and later transcribed the interview in entirety.

2.1.2 Data analysis

Interviewers took notes during the interview itself and memoed shortly thereafter. Memoing provides a formal opportunity for a researcher to engage with the data through both exploration and interpretation (40). Although there is no prescribed formula for memos in qualitative research, some of their primary functions are to extract meaning from the data, maintain momentum, and facilitate communication within the research team (40).

Data collection and the analytic process was iterative; that is, we began reviewing data as they were collected in order to identify recurrent themes, draw initial connections between ideas, and establish thematic saturation. Using ATLAS.ti software to manage the data, we conducted a content and thematic analysis of the interview transcripts.

Content analysis refers to a systematic method to make valid inferences from verbal, visual, or written data in order to describe a specific phenomenon (41). Content can refer to a variety of data, and can include anything from newspaper articles to web pages to interview transcripts (42). Although content analysis is often described as “counting” various aspects of

content, it is not solely concerned with quantifying data. Rather, it aims to investigate meanings, intensions, consequences, and context by identifying key words, phrases and sentences (43).

Essentially, this method serves as a way to summarize data in a systematic way.

In contrast, thematic analysis reaches a stage of interpretation and is a method for “identifying, analysing, and reporting patterns (themes) within data” (44, p82). Thematic analysis is a flexible process that is concerned with looking across a data set rather than within a single item. It is important to acknowledge that themes are not dependent on quantifiable measures; simply counting the instance of a pattern occurring is insufficient. Researcher judgment is necessary in determining themes and this process is often driven by the particular research questions and analytic frameworks related to the project (44).

In our analysis of the OAS data, we used both *a priori* (pre-determined) categories and codes based on the study aims and research questions, and inductive techniques to identify emergent findings and themes. Inductive analysis is a data driven, “bottom up” approach to analysis (45). This technique allows the theory to emerge from the data because during the coding process, the researcher does not try to fit the data into a pre-existing coding frame (46).

The content of the interviews combined with insights derived from the memos allowed for the creation of an initial code book which I used to code all of the data. The coding was reviewed by my supervisor, and any disagreements were resolved through discussion. We then began the process of identifying recurrent themes, drawing connections between ideas, and interpreting relationships among themes and concepts.

2.1.3 *Findings related to this study*

During the iterative data collection and analytic process of OAS, we noticed an emergent theme regarding women's experiences with post-abortion support. Following their termination, a subset of participants expressed a desire for non-judgmental support. Fully, one third of the women that we spoke to mentioned this. However, these same participants also noted that they had difficulty finding and accessing such a service. These results contributed to the motivation and rationale for this study as they highlighted a gap in service provision. The results are discussed in depth in Chapter 3 of this thesis.

2.2 Phase 1: Directory of post-abortion support services in Ontario

When I analyzed the OAS data, I found that women seeking post-abortion support services identified three strategies to search for services: 1) searching online; 2) calling the freestanding clinic where their termination was performed; or 3) calling their local Public Health Unit (Chapter 3, this thesis). I utilized these same strategies in searching for services and compiling the directory.

I employed a rigorous searching strategy. To begin, I searched online using a pre-determined set of search terms. In many cases, the websites that I found when searching online contained links to other websites and/or organizations. I followed through on all pertinent links and documented the information. Next, I called all Public Health Units (PHUs) and abortion clinics in Ontario. I obtained comprehensive lists of these organizations' locations from the Ontario Ministry of Health and Long-Term Care and the Abortion Rights Coalition of Canada, respectively (47, 48). I limited the number of contacts with each PHU and abortion clinic to five calls in order to mimic the interaction of a woman seeking these services.

When I called the abortion clinics and Public Health Units, they did not identify any organizations that I had not already documented while searching the internet. This served as confirmation that my initial online search had been thorough in identifying post-abortion support services in the province.

I recorded all services that were recommended to women by an abortion clinic or PHU as a post-abortion support service, or advertised itself as providing dedicated post-abortion support in online advertising. However, I only included organizations that offered free, one-on-one services in the final version of the directory. I also included talklines that are national (or bi-national US-Canada) in scope and therefore not bound by provincial geography.

For each service that met the inclusion criteria, I noted the service type, location, and availability, as well as their contact information and website. I then compiled this information into a database. Although this database served primarily as a reference point for subsequent phases of the project, I examined it in conjunction with the number and geography of abortion providers in the province. Further, the process of searching for services using the methods identified by women provided me with valuable insight into the landscape of post-abortion support in Ontario.

2.3 Phase 2: Document analysis

Document analysis is a qualitative methodology which involves a systematic review of organizational and institutional documents in order to better understand their intended purpose, message, and audience (49). Indeed, while official documents are meant to be read as objective statements, they are still socially constructed and socially produced for a specific purpose.

Documents included in a review can take a variety of forms, including printed and electronic, such as advertisements, brochures and pamphlets, journals, press releases, and more (50).

While document analysis is a valuable method in its own right, it can also be an invaluable means of triangulation (49). Triangulation involves using a combination of methods to study the same phenomena and is a way to explore convergence, complementarity, and dissonance (51). For the purpose of this thesis, the document analysis of organizations' web presence is important to better understand how organizations describe their services and discuss abortion. It also provided a preliminary examination of the frameworks used to offer post-abortion support that I further explored by mystery client interactions, as described in Section 2.4 of this chapter.

2.3.1 Data analysis

I included all of the organizations that I identified in Phase 1 of this project in this component of the study. I elected to analyze the web presence of providers in lieu of other advertisement media for a number of reasons. First, all organizations that I identified had a designated web presence to discuss their provision of post-abortion support, meaning that it is the most consistent advertising medium across organization type. Second, when asked about their experiences seeking post-abortion support, women specifically mentioned that they would search online (Chapter 3, this thesis). Consequently, I believe that the online presence of these organizations represents the most searched for and accessed advertising medium.

For the purpose of this analysis, my supervisor and I independently examined the organizations' web presence that related specifically to post-abortion support and their provision of this service. We used ATLAS.ti software to manage all of the data for this component of the

study and conducted both content and thematic analysis. To do this, we used *a priori* codes and categories based on the study research questions, as well as inductive techniques to identify emergent findings and themes.

I began the analytic process with a close reading of the data. This served to familiarize myself with the web presence of each organization offering post-abortion support. Using a codebook that my supervisor and I created together, we separately coded the web presence of each organization. Once we had each finished coding, we worked together within each code to identify principal sub-themes that reflected finer distinctions in the data. Through discussion, we were able to identify recurrent themes and began to draw connections between ideas. Finally, we turned to the interpretation phase of our analytic plan in which we focused on identifying relationships among themes and concepts. Any disagreements in the coding and interpretation process were resolved through discussion.

2.4 Phase 3: Mystery client interactions

The mystery client method involves a trained individual or researcher visiting a program facility or seeking services in the assumed role of a client. The researcher then reports on her experiences. Mystery client interactions have become increasingly common in health sciences research and are often used to evaluate the provision of services, monitor site improvements, and gain a greater understanding of the dynamics of the interaction between client and service provider (52, 53). The mystery client method has been frequently used around the world to evaluate the provision of family planning services (54-56). This method is especially important in circumstances where it is reasonable to believe that participants would demonstrate social desirability bias; that is, in situations where participants would likely respond in a different way

if they knew they were being monitored, evaluated and/or observed (57). Given the documented deceptive tactics used by crisis pregnancy centers across Canada and the US to dissuade women from seeking abortion services (37-39), I believe that the mystery client method provides the only reputable way to investigate the services offered at these organizations.

2.4.1 Training and preparation for mystery client interactions

In preparation for this research project, I served as the Study Coordinator for the Ontario Abortion Study. In this role, I interviewed women from across the province about their abortion experiences. This allowed me to become familiar with the way women talk about their terminations. Although the 60 women that we interviewed described a variety of circumstances and feelings surrounding their abortion, we were also able to identify common themes and I gained a greater understanding of the circumstances that often lead women to seek post-abortion support. Based on this information, I created a client profile (Appendix A) specifically for this study with input from my supervisor. Although we modeled the profile after OAS interviews, it is in no way identifiable. I also created a list of standardized prompts in order to increase consistency between interactions taking place at different organizations (Appendix B).

Following the creation of the client profile, I practiced the interactions with my supervisor. Based on her feedback, I revised the profile slightly and continued to rehearse the interactions both independently and with colleagues, before working with two former talkline volunteers. The volunteers had each previously worked for a minimum of 12 months at a bi-national talkline that offers post-abortion support. However, neither of the volunteers were still involved with the line when I was in contact with them, and thus practicing with them did not affect my ability to maintain the status of a mystery client with the organization. These

interactions were essential in establishing the credibility and authenticity of the profile and were valuable opportunities for me to practice in the role of a mystery client. I worked with the former volunteers separately and incorporated their feedback and suggestions into the final version of the client profile and list of standardized prompts.

2.4.2 *Data collection*

Of the organizations I identified that offer free, individualized post-abortion support services in Ontario, I contacted all of the organizations that offered phone-based services or did not specifically mention that they only offer in-person services. I carried out all of the interactions over the telephone and audio recorded them. I started each call by saying “I recently had an abortion and I don’t have anybody to talk to about it”. Using the client profile, I then responded to any questions posed by the counsellor/service provider. I conducted all interactions in English and they developed organically through the course of the phone call.

Originally, I had planned to conduct a second interaction at each organization after one month following the initial call. However, in the process of carrying out the mystery client interactions, it became clear that the majority of organizations have a very small staff and that I would be speaking with the same person during the second call. This indicated that maintaining the status of a mystery client and carrying out a second call would not be consistently feasible. Further, many organizations refused to provide services anonymously over the phone, and consequently fewer full length interactions took place than I had originally planned for. However, this did not affect the ability to reach thematic saturation.

At no point did I reveal myself as a mystery client to the service provider and I did not solicit any personal information from the counsellors. The sessions ended once they had reached

an organic conclusion, or at the time-point of one hour, whichever came first. The interactions lasted for an average of 20 minutes and immediately after the encounter, I evaluated the interaction using a checklist which I developed specifically for this project. The checklist included criteria related to positive counseling techniques, tone, and accuracy of information and is based on criteria that have been identified as integral in compassion based communication and active listening (58, 59). I also memoed extensively following each interaction to record my immediate thoughts and reactions to the call. I transcribed all mystery client interactions in entirety, and my supervisor audited a selection of the transcripts for accuracy.

2.4.3 *Data analysis*

I used ATLAS.ti software to manage the memos, checklists, and transcripts from the mystery client interactions. The analytic process for this component of the study was meant to be iterative, such that I began reviewing data as they were collected. Just as with the analysis of the OAS data and Phase 2 of this project, for this component I carried out a content and thematic analysis using both *a priori* codes and categories, as well as inductive techniques.

I began with familiarizing myself with the data: I listened to the audio recording files and re-read the memos and transcripts using active reading techniques. This allowed me to create initial codes based on the interactions' content, before I moved on to search for themes within the dataset. My supervisor also listened to the interactions and reviewed the transcripts. We collaboratively reviewed the themes I had identified before we moved to define and name said themes.

2.5 **Ethical considerations**

This study received approval from the Health Sciences and Sciences Research Ethics Board (REB) located at the University of Ottawa (file #H03-14-07). The letter of approval from the University of Ottawa's REB can be found in Appendix C. The Ontario Abortion Study was approved as a separate file (file #H08-12-08) and can be found as Appendix D.

2.6 Conceptual framework

Primarily, this project was intended to be pragmatic, action-oriented research. As a form of action-oriented research, action research is specifically concerned with producing research that has social relevance and can address practical concerns (60). Although action research does not have a prescribed methodology, after extensive discussion with my supervisor, we decided that qualitative methods would be the best way to explore the research questions and yield detailed, rich, and complex results.

Qualitative methods are often used to investigate previously unexplored phenomena (46, 61). Given that post-abortion support in Ontario has not previously been investigated and that anecdotal evidence accounts for the majority of what is known on the topic, qualitative methods provide a way to rigorously explore the issue 'from the interior' (62). They also provide a valuable way to begin to understand the what, why, and how of a phenomena. The specific methods that we selected for this project allowed us to explore post-abortion support while prioritizing women's experiences by mimicking their process of searching for and accessing services. Finally, the mystery client method also provides a practical way to counteract social desirability bias (53).

Chapter 3: “I kind of feel like sometimes I am shoving it under the carpet”: Documenting women’s experiences with post-abortion support in Ontario

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Abstract

Background: Abortion has been legalized without federal restriction in Canada for more than 25 years. Ontario is Canada's most populous province with more than 33,000 terminations reported annually. The majority of women receive abortion care from 13 clinics across the province, and there are also a number of providing hospitals.

Objectives: This study aimed to explore women's expressed desire for post-abortion support services, document the priorities expressed by women in seeking post-abortion support; and identify actionable strategies to improve post-abortion support services across Ontario.

Methods: In 2012-2013, we conducted in-depth, open-ended interviews with 60 Anglophone women from five regions of Ontario who had recently had an abortion. We purposively recruited women from two different age groups, 18-24 and 25 and above, and aimed to rigorously explore the compounding issues of age and geography on women's abortion experiences. We analyzed our data for content and themes and report on the findings related to post-abortion support.

Results: One third of our participants expressed a desire for post-abortion support, yet few were able to access a timely, affordable, non-directive service. Women were uncertain about how to find services; most contacted a provider recommended by the clinic or searched online. Women, especially those without supplementary insurance, found wait times and costs prohibitive. Women were enthusiastic about a talkline format citing anonymity and convenience as the main advantages.

Conclusion: There is a demonstrated need for post-abortion support services across Ontario. Expanding efforts to improve access to timely, affordable, and non-judgmental services appears warranted.

Introduction

Abortion has been legalized without federal restrictions in Canada for more than two decades and is one of the most common medical procedures experienced by women of reproductive age. Indeed, more than 90,000 abortions are performed each year and one in three Canadian women will have an abortion during their lifetimes (Canadian Institute for Health Information (CIHI) 2012; Norman 2012). As Canada's most populous province, more than a third of the country's terminations take place in Ontario (CIHI 2012). Despite the prevalence of the procedure, the stigma surrounding abortion in the Canadian political and social climate often silences women's voices, leaving them with few opportunities to share and discuss their abortion experiences. While there is a substantial body of evidence to indicate that the majority of women do not experience negative mental health outcomes after an abortion (Steinberg & Finer 2011; Major et al. 2009; Robinson et al. 2009; APA Task Force on Mental Health and Abortion 2008; Steinberg & Russo 2008), it has been shown that women can experience a complex range of emotions following a termination and may benefit from a space to talk about them (Kimport, Perrucci & Weitz 2012; Weitz et al. 2008).

In recent years, opponents of abortion rights have made repeated attempts to tie abortion to a variety of mental health conditions (Kelly et al. 2014; Steinberg et al. 2012a; Steinberg et al. 2012b). In fact, discussion of post-abortion support in the public domain often centers on "post-abortion trauma," "post-abortion syndrome," and "post-abortion stress." Although there is no evidence to support the existence of such "syndromes" these claims have had significant policy implications, including the justification of mandatory information sessions and waiting periods for women seeking services (Robinson et al. 2009; NARAL Pro-Choice America 2011). Further, despite the overwhelming medical evidence to the contrary, some US states require clinicians to

inform patients that abortion will result in an increased risk of mental health problems, including depression and suicidal ideation (Robinson et al. 2009). In a 2006 evaluation of state-mandated abortion counseling materials, researchers found that 19 of the 22 states with such laws include information about the psychological effects of abortion (Richardson & Nash 2006). More specifically, in seven of these states, the mandated counseling materials detail the supposed negative mental health outcomes from abortion, such as regret, anxiety, depression, drug abuse, suicidal ideation, and “postabortion traumatic stress syndrome” (Richardson & Nash 2006). It is important to note that this information is in direct contrast with the official statement of the American Psychological Association, which has also strongly advised against mandated counseling for women seeking a termination (APA Task Force on Mental Health and Abortion, 2008).

The efforts to pathologize abortion have had a chilling effect such that it has become increasingly difficult to explore the full range women’s experiences after an abortion. Indeed, the most prevalent social narratives about abortion outcomes are typically limited to regret or relief, even though some women fall in between on the emotional spectrum (Weitz et al. 2008).

To date there is very little research focused on women who have negative emotional outcomes following an abortion because the concept of abortion regret is so often associated with a woman’s attachment to the fetus and pregnancy. This serves to perpetuate the stigma that already abounds in abortion discourses by positing the abortion procedure as the cause of negative emotions and mental health outcomes. Not only is this insufficient as it fails to take into account a variety of factors that leave women with few opportunities to discuss their experiences, it is also contrary to what has been found in the literature.

Indeed, the literature strongly supports that social factors, such as the decision-making process before the abortion and the process of finding social support afterward, play a large role in emotional outcomes following a termination (Kimport, Foster & Weitz 2011). Other social factors that have been found to be associated with post-abortion outcomes include feelings of stigma and perceived need for secrecy, social disapproval, exposure to anti-abortion picketing and protesters, the loss of a romantic relationship, and emotional conflict surrounding the decision to terminate (APA Task Force on Mental Health and Abortion, 2008; Kimport, 2011; Major & Gramzow, 1999).

Despite this emerging literature, to date women's voices have been notably absent from the discussion of post-abortion support. We know very little about what the demand and priorities are for this type of service. This study aimed to address these gaps by documenting women's stories and exploring their experiences with post-abortion support in Ontario.

Methods

In 2012-2014, we conducted in-depth, open-ended telephone interviews with 60 Anglophone women from across Ontario. All participants had an abortion within five years of the start of the study period and resided in the Greater London, Ottawa, Thunder Bay, Timmins/North Bay, or Toronto regions at the time of the termination. We purposively recruited women from two different age groups, 18-24 and 25 and above, and aimed to rigorously explore the compounding issues of age and geography on women's abortion experiences.

We used a multi-modal recruitment strategy which included placing social media ads, establishing a study website, circulating study information on listservs, and posting flyers in community venues. Women interested in participating contacted the Study Coordinator (KL)

who then conducted eligibility screening, provided additional information about the study and the consent form, and scheduled the interview on first come/first served basis.

The PI (AF) and/or a trained member of the all-female study team conducted all interviews after obtaining informed consent. Interviewers used the same interview guide that asked participants a series of questions related to demographics, background, sexual, contraceptive, reproductive, and pregnancy history, as well as their general experiences accessing both primary and reproductive health services. We then asked participants about their abortion experience(s), including the circumstances surrounding the pregnancy and abortion, the process of locating a provider, scheduling an appointment, obtaining the service, and receiving follow-up care. We also asked women about their retrospective feelings about both the decision and the experience itself, as well as ways in which abortion services in Ontario could be improved. Interviews lasted an average of 60 minutes and with the permission of participants we audio-recorded and later transcribed them. Interviewers took notes during the interview and formally memoed shortly thereafter. All participants received a \$40 gift card to amazon.ca as a thank-you for their time.

We began reviewing data as they were collected in order to identify common elements, draw initial connections between ideas, and establish thematic saturation. We conducted a content and thematic analysis of interview content using both *a priori* (pre-determined) categories and codes based on the research questions and inductive analysis techniques to identify emergent ideas. The content of the interviews combined with insights derived from the memos allowed for the creation of an initial code book which the Study Coordinator (KL) used to code all data. We used ATLAS.ti to manage our data, including notes, memos, and transcripts. The PI (AF) reviewed the codebook and coded transcripts. Guided by regular team meetings and

discussion, our thematic analysis centered on grouping categories of information, drawing connections between ideas, and understanding relationships.

In this article we focus specifically on the findings related to post-abortion support. We have removed and/or masked all personally identifying information and have used pseudonyms throughout. This study was approved by the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H08-12-08).

Results

Participant characteristics

Participants (N=60) ranged in age from 18 to 48 and were evenly divided into two age cohorts: 18-24 (inclusive), and 25 and older at the time of the interview. The majority of participants self-identified as white and all were Canadian citizens. Our 60 participants had 73 abortions since January 1, 2007; the overwhelming majority took place during the first trimester. The majority of women also had their abortions at freestanding clinics (n=40) as compared to those who had their termination at a hospital (n=21) or hospital-based clinic (n=9). A minority of participants (n=3) had medication abortions using the methotrexate/misoprostol regimen, provided either by a clinic, hospital, or doctor's office.

One third of participants expressed a desire for post-abortion support following their termination. These participants ranged in age from 18 to 48 years old and predominantly self-identified as white. These women's terminations also overwhelmingly took place during the first trimester, and took place at a variety of facilities, including freestanding clinics, hospital based clinics, and hospitals across all of the geographic regions we included in the study. Consistent with the overall sample, women who were interested in post-abortion support described a variety

of circumstances leading up to, and a broad range of emotions after, their abortion. However, there were a number of themes that emerged in this sub-set of interviews which we detail below.

Women's desire for post-abortion support was not associated with mental health issues

I kind of feel like sometimes I am shoving it under the carpet...My parents don't even know. His parents don't know. So it's like, it's just one of those things. It's like I can't just talk about it to anybody. It's really hard because I feel like I want to keep it on the down low, but who else do I go to? Or [who] else is going to understand? (Alexis, aged 21, Ottawa).

Of the women who were interested in post-abortion support services, only three described themselves as having a history of mental illness, specifically depression and anxiety. In two of these cases, women had a pre-existing relations with a psychiatrist or psychologist and were disappointed in the reaction of the therapist to their disclosure of the abortion.

Rather than the desire of post-abortion support being related to overarching mental health conditions, almost all of the women who desired post-abortion support described having a lack of social support. The stigma that surrounds abortion procedures was mentioned frequently. Taylor, a 28 year old woman from Ottawa who accessed services through her work benefits explained, "Now it's like talking about it helps to take away the shroud [of stigma]." Often women did not feel that the abortion was an appropriate topic of discussion to bring up with those who they would have otherwise considered to be a source of emotional support. Other times, women felt that there was a lack of understanding of their experience from their partner, friends, and/or family. Madison, aged 21, from Toronto, explained, "[Having post-abortion support provided] would have benefitted me in the sense...[that when] I tried bringing it up to my boyfriend...he couldn't understand why I was getting so upset about it now."

For these reasons, women expressed an interest in having someone to talk to outside of their usual network of friends and/or family. As Alice, a 30 year old woman from North Bay, explained,

If I had been given a counsellor's number, someone you know, whether it's a support group or anything to talk to, at that point I think would have been the ideal time...There was a few times during the first year or two where it was rough thinking about [the abortion]. But I wouldn't say I regret what I did, just maybe if I had someone to talk me through the emotional side of things.

Consistent with Alice's experience, the women we spoke to often noted that they did not regret the decision to terminate the pregnancy. Rather, women expressed regret and sadness about the life circumstances that necessitated or surrounded the abortion, not the abortion itself.

Women had difficulty accessing desired services

I definitely tried looking but I didn't really feel like I was finding...the right thing...Maybe I wasn't typing in the right thing. But I felt like no matter how specific I was trying to get, I was...just finding random counselors and psychiatrists or psychologists. I wasn't really finding someone who maybe specializes...or, you know...people who have dealt with that kind of thing before. (Alexis, aged 21, Ottawa)

Despite their desire for post-abortion support, few women in our study were able to find and access desired services. Participants identified three methods of searching for post-abortion support services: searching online, calling the clinic where the procedure was performed, or calling their local Public Health Unit (PHU). Women who had hospital-based abortions were especially likely to have contacted a PHU.

In searching online for available services, women found the abundance of anti-choice information on the internet to be challenging to sort through. When they searched for post-abortion support services, many women reported finding services that fell into one of two categories: paid for, clinical counseling services, or anti-choice/anti-abortion services, many of

which were religiously-affiliated. As described by Molly, aged 22, from London, “It’s much easier to get information from a person than it is from a web page...On the internet there’s basically websites that are telling you one thing, and then there’s another website that’s telling you the opposite. You have to interpret the information from both.”

Several participants did access formal counseling services, but this was typically because of a pre-existing referral to a mental health professional. Some other women were able to access these services through employee assistance programs or insurance benefits which helped to cover the cost. Women without insurance found both the cost and the wait-times to be extremely prohibitive in accessing formal counseling services following their abortion. As Hannah, aged 35 and a resident of Ottawa at the time of her abortion explained,

I think that immediately after the procedure, maybe in the month or two right after...I think that would be the time to have access to counselors. Because I found that I had to wait – I think that I had to wait at least three weeks even to just have that one appointment...I only went once. And I think that the cost is difficult.

Several women also noted that they were unable to find a service that seemed specific enough for the kind of support they were looking for. Women explained that they were hesitant to access a general counseling service or general talkline for fear of judgment, or because they felt like there would be a lack of understanding of their experience.

Women expressed considerable interest in non-directive, non-judgmental services

I mean if [a talkline] was presented as this is a non-judgemental resource – it’s anonymous, it’s confidential for potential support – I mean that sounds pretty good, but at that time you know I think how isolated I was from support, I feel like anything could have helped. (Shannon, aged 25, Toronto)

Women identified several priorities for post-abortion services. Primarily, women noted confidentiality and/or anonymity as a major concern. Closely linked with this was women’s

desire for a non-judgmental service. Women noted that abortion often felt like a taboo topic of discussion and therefore they wanted assurance that if they were discussing their experience, it was in a neutral space.

In addition, women wanted services that were either low-cost or free. Many women cited financial constraints as one of the reasons for obtaining their abortion, and thus having fees associated with post-abortion support services was prohibitive. As Erin, a 25 year old woman from Ottawa explained, she was unable to access services following her termination because she lacked insurance coverage to help cover the costs:

I think that there should be more free counseling in regards to stuff like that, because in my opinion it's way too expensive. I...could have used counseling afterwards, but I didn't get any because I wasn't covered. I didn't have the money and [neither] did my parents.

Our participants were often enthusiastic about a talkline format of post-abortion support services as it combined anonymity, no-cost, and increased flexibility for scheduling in comparison to an in-person service. About the talkline format, Erin went on to say that “Especially...[for] younger women [who] may not feel comfortable sitting in front of someone. Sometimes being behind a phone is easier, right? So a phone number...like a hotline or something like that. And not just for young girls [because] it's hard [for anyone] to talk about something like that.”

Discussion

An August 2014 article published in the Washington Post urged both health care providers and pro-choice organizations to stop referring to abortion as a “difficult decision” for women (Harris 2014). The author argued that by assuming abortion is a difficult decision, we assume that women need help deciding and that this paves the way for mandated counseling

laws. These laws are often based on medically inaccurate information and are designed to dissuade women from having abortions (Richardson & Nash 2006). The author also argued that the “abortion as a difficult decision” dialogue further stigmatizes the procedure.

Harris’ point is well taken. The anti-choice movement has shifted its narrative from focusing on the fetus to focusing on women (Saurette & Gordon 2013). In this way, they have seized an “abortion harms women” message that presents abortion as a trauma and the decision to have one as tortured (Kelly 2014). This has certainly seeded efforts to impose restrictions on abortion access (Lazzarini 2008; Richardson & Nash 2006). However, both versions of the polarized discourse – that abortion is always a difficult decision for women, or that it is never a difficult decision for women – are detrimental. In recent years there have been efforts to acknowledge the range of emotions and pluralize women’s experiences (Weitz et. al, 2008).

That women express a range of emotions after an abortion – including feelings of sadness and isolation – is not surprising and our findings are consistent with the broader literature (Kimport, Foster & Weitz 2011; Weitz, Moore, Gordon & Adler 2008). The experiences of our participants highlight that negative or complex emotions are distinct from mental illness and that a desire for support in the post-abortion period is not a reflection of an underlying pathology. This distinction is important from both a policy and service delivery perspective, as well as the social perspective.

Our study found that in Ontario there is a disconnect between women’s expressed desire for post-abortion support services and the accessibility of these services. Women consistently cited difficulty and/or an inability to find post-abortion support that was low-cost or free, did not have an extended wait time associated with it, and was confidential and non-judgmental. That

these services also need to be structured in a way that is non-judgmental and woman-centered is of primary importance.

Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, the method is not intended to yield representative and generalizable results. Although multi-modal recruitment of a purposive sample of women who resided in Ontario at the time of their abortion gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends.

Implications for policy and practice

Our results indicate that the expanded provision of post-abortion support in Ontario is warranted. Further, in the expansion of these services, women's preferences need to be considered. The talkline format provides a viable way to expand the provision of post-abortion support while taking into account women's expressed priorities for services. Not only are talklines anonymous, which is important given the stigma that continues to surround abortion, but because women can call from anywhere or at different times of the day, this format provides increased convenience.

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Chapter 4: “Living in Color”: Exploring the online presence of organizations offering post-abortion support services in Ontario

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Abstract

Title: “Living in Color”: Exploring the online presence of organizations offering post-abortion support services in Ontario

Objectives: Previous research has indicated that women in Ontario have an established need for post-abortion support, yet often have difficulty finding and accessing affordable and timely services. We aimed to determine what free post-abortion support services are available to women in Ontario, the kinds of organizations offering these services, and how these services represent themselves.

Methods: In previous research, women identified three primary ways in which they searched for post-abortion support services: searching online, calling the clinic where their abortion was performed, and calling their local Public Health Unit. We utilized these same methods to create a directory of free services in Ontario. We then reviewed organizational websites and conducted a content and thematic analysis of the online presence of these organizations. We specifically focused the medical accuracy of the provided information and the tone, frameworks, and assumptions of the employed discourse.

Results: We identified 41 unique organizations that offer post-abortion support in Ontario; 33 crisis pregnancy centres (CPCs), two sexual health centres, three religiously affiliated talklines, and three secular talklines. We were able to most easily find information about CPCs. All organizations described their services as confidential and non-judgmental, but CPCs and religiously affiliated talklines included negative and stigmatizing language about abortion, as well as medically inaccurate information, on their websites.

Conclusion: CPCs account for the majority of organizations providing free post-abortion support services to women in Ontario. Efforts to increase the online visibility and overall accessibility of non-judgmental, non-directive, medically accurate post-abortion support services in Ontario appears warranted.

- Crisis pregnancy centres represent the majority of organizations in Ontario offering free post-abortion support services.
- Crisis pregnancy centres and faith based phone lines often used shaming and stigmatizing language in their online presence to talk about abortion.
- Increasing the visibility of existing non-judgmental, non-directive, medically accurate post-abortion support services appears warranted.

INTRODUCTION

In 1988, the landmark *R v. Morgentaler* decision decriminalized abortion across Canada.[1] Today, the ruling remains unchanged and without any federal restrictions on the procedure, Canada has one of the most liberal abortion laws in the world.[2] Nonetheless, since its decriminalization, abortion remains a socially contentious issue. In recent years, there has been a shift in the anti-abortion discourse, both in Canada and worldwide, to portray abortion as harmful to women.[3]

Yet, the safety of induced abortion care when provided in legal environments by trained health service professionals has long been established.[4-6] Further, a body of research has demonstrated that in comparison to the delivery of an unintended pregnancy, abortion is not associated with an increased risk of mental health problems.[7-10] However, evidence suggests that opponents of abortion rights have made repeated attempts to tie abortion to a variety of mental health conditions[11-12], and most recently, this effort has been dedicated to the establishment of “post abortion syndrome” and “post abortion stress” as diagnoses.[13-14] There is no evidence to support the existence of such “syndromes” and neither the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) nor the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) recognize their existence.[15-16] This is consistent with an official statement issued by the *American Psychological Association* that concluded that a single first trimester abortion is not associated with adverse mental health outcomes, including depression and anxiety.[17]

Still, as with any life event that can represent an important decision, women can experience a complex range of emotions following a termination and may require a space to process them.[18] Previous research has indicated that some women in Ontario, Canada’s largest

and most populous province, desired non-judgmental post-abortion support services after their termination.[19] However, these same women noted that they were unable to find and access an affordable and timely provider.[20] Our objective was to identify organizations offering post-abortion support in Ontario, and to evaluate their online presence.

METHODS

Our study utilized a two-step approach to investigate post-abortion support services in Ontario. First, we created a directory of free services across the province. Second, we conducted a qualitative document analysis to analyse the web presence of post-abortion support providers in Ontario.

Data collection

Previous research conducted with women in Ontario found that women seeking post-abortion support identified three strategies to search for services: 1) searching online, 2) calling the clinic where their termination was performed, or 3) calling their local Public Health Unit.[19] We utilized these same strategies to search for services and compile the directory. In the fall of 2014, we searched online using a pre-determined set of search terms. In many cases, the websites that we found when searching online contained links to other websites and/or organizations, which we followed. Next, one investigator (KL) called all Public Health Units (PHUs) (n=35) and freestanding abortion clinics (n=9) in Ontario. We obtained comprehensive lists of the PHUs and clinics from the Ontario Ministry of Health and Long-Term Care and the Abortion Rights Coalition of Canada, respectively.[21-22] We limited the number of contacts with each PHU and abortion clinic to a total of five calls. When we reached an appropriate person via the telephone,

we asked for contact information for free post-abortion support services. We specified that we were not looking for a service provided by a clinician or for someone in crisis.

Based on our online search strategy and the recommendations from both PHUs and clinics, we assembled a list of post-abortion support providing organizations. We ultimately narrowed our list to organizations that provided free, one-on-one services. For each organization that met the inclusion criteria, we noted the service type, location, and availability, as well as their contact information and website address. This yielded 41 unique organizations.

Following the creation of the directory, in late 2014 through early 2015 we analysed the web presence of each of the 41 post-abortion support providers serving women in Ontario. We modelled our approach after other published studies that evaluated online content.[23-25] Two investigators independently and systematically reviewed all posted content on each website. This typically began with the homepage and then involved following all tabs, uploaded documents, and internal links. We noted external links but did not analyse the content of external sites. Using a coding sheet, each investigator reviewed post-abortion related content for medical and legal accuracy, tone, frameworks, and underlying assumptions. Each investigator took notes and formally memoed throughout the process and took screen captures of exemplar content.

Data analysis

After each investigator had reviewed all content, we compared coding sheets, shared notes and memos, and discussed our evaluation. Our assessment was exceptionally consistent and both investigators often chose the same exemplars. We resolved our rare disagreements through discussion. We used ATLAS.ti to manage our data, including notes, memos, and text from the websites. After evaluating and characterizing the content, we then turned to our

thematic analysis, which centred on grouping categories of information, drawing connections between ideas, and understanding relationships.

Ethical considerations

As our study did not involve engagement with human subjects and focused on publicly available information, we did not require Research Ethics Board approval.

RESULTS

Finding services

We identified 41 unique organizations that offer free, one-on-one post-abortion support in Ontario. The overwhelming majority (n=33) of these organizations identified themselves as crisis pregnancy centres (CPCs). The remaining eight organizations included three binational (US-Canada) religious talklines, three secular national and binational (US-Canada) talklines, and two sexual health centres.

When searching for services online, we found that CPCs not only account for the majority of service providers, but also consistently ranked first in search results. In contrast, sexual health centres and secular phone lines that offer post-abortion support were much harder to find through standard online search engines (including Google, Bing, and Yahoo) and often did not appear within the first few pages of search results.

Our calls to PHUs were met with inconsistent responses. It took an average of three calls to each PHU to speak to an appropriate person. Of the 35 PHUs that we called, we received no response from 12 of these organizations. In these cases, we were either unable to get in touch with anyone at the unit after five calls (n=7), or the PHU told us that no such service existed

(n=5). We classified eight PHUs as giving us general or inappropriate referrals: three referred us to fee-for-service providers and five recommended we contact a general service, such as a mental health crisis line or a database of Ontario's community and social services. Two PHUs referred us to a CPC; one of these PHUs also recommended we contact the hospital where the abortion was performed. Of the remaining health units, three informed us about in-person services available at the PHU, three advised us to call the facility where the abortion was performed, two referred us to a local sexual health centre, and five PHUs referred us to a combination of these services.

In contrast, the information provided by the abortion clinics was much more consistent and streamlined, as it rarely took more than one call to speak with an employee. Three clinics provided a referral to a secular talkline, four clinics referred us to in-person services available at a nearby sexual health centre or the clinic itself, and two clinics provided us with information about a combination of these services.

Description of services

All organizations emphasized that the support they provide to clients is both non-judgmental and confidential. Although some organizations mentioned that an appointment is required for services, most indicated that they are able to work with clients on a walk-in or call-in basis. All of the talklines identified themselves as religious or secular. Only a minority of CPCs identified themselves as religiously-affiliated, and only two centres stated on their websites that they do not offer phone-based services. The majority of CPCs were located in Southern (n=18) and Central (n=10) Ontario, which is reflective of the distribution of abortion providers in the province.

The framing of post-abortion support differed considerably between different organization types. Crisis pregnancy centres positioned abortion as something that required recovery and their organizations as facilitators of that process. As written on the website of a CPC serving women in Central Ontario, “[We] offer a post-abortion recovery and healing program...” Another CPC serving women in Western Ontario stated, “[We offer a] program that allows you the opportunity to face your decision, grieve your loss and promote healing.”

Religious talklines similarly framed post-abortion support as a healing process. As noted on one website,

[This] is a safe place to renew, rebuild and redeem hearts broken by abortion...[We] offer you a supportive, confidential and non-judgmental environment where women and men can express, release and reconcile painful post-abortive emotions to begin the process of restoration, renewal and healing.

In contrast, two sexual health centres and three secular phone lines described their services as client-driven and did not frame the abortion experience, “[We] provide the opportunity to talk with someone who supports and respects you, in a safe and confidential environment.”

Medical accuracy

Crisis pregnancy centres were the only type of organization to provide medical information when describing their services and six included medically inaccurate information. These websites often mentioned “post abortion stress” and “post abortion syndrome” and listed symptoms associated with each. For example, the website for a CPC serving women in Southern Ontario claims,

Post Abortion Stress is described as the inability to: Process the painful thoughts and emotions about a crisis pregnancy and subsequent abortion – guilt, anger and sorrow; Identify the loss that has incurred; Come to peace with self and others.

On these websites, abortion is frequently associated with depression, grief, suicidal tendencies,

eating disorders, and drug addiction. As asserted on one CPC website serving women in Southern Ontario,

Women come to the center hoping to resolve feelings of guilt, anxiety and depression. Women also inform us of secondary symptoms such as flashbacks of the abortion procedure, addictions, eating disorders, self harm, anniversary syndrome, spiritual disconnection, preoccupation with becoming pregnant again, and interruption of bonding with future children.

No websites purporting a link between abortion and negative mental health outcomes referenced peer-reviewed materials. However, several CPC websites referred to “recent research” that links negative mental health outcomes and abortion without providing a reputable citation.

Language related to abortion

Abortion has long term effects of sorrow, grief and guilt. It leaves wounds that tear at our very fabric, that scab over but never heal, and undermine our relationships with others. (Website of a CPC serving women in Central Ontario)

The language used to talk about abortion represents another key difference across organization type. Crisis pregnancy centres and religiously affiliated talklines consistently used language associated with negative emotions and feelings to describe the post-abortion period. For example, the website of a CPC serving women in Southern Ontario stated,

Your abortion was supposed to end your crisis and you just wanted things back to normal again. Instead, it has left you feeling empty. The memories of your abortion are difficult to face and you are feeling angry, depressed and alone.

With rare exception, these organizations discussed the abortion experience as a loss that requires a post-abortion grieving process. As spelled out by one CPC, “[The Center] is a compassionate place to work though the difficult emotions that are often felt after an abortion loss. Sometimes it is years after the abortion that someone will begin to look for help...Grieving the loss and being able to move forward is possible.”

Further, CPCs tended to pathologize the abortion process, using medicalized words such as “symptoms,” “trauma,” and “syndrome.” Although some CPCs did acknowledge that women can experience a broad range of feelings, including relief, these websites presented women who have neutral or positive feelings after their abortion as outliers to the typical negative psychological outcomes that follow a termination. As described by a CPC in Central Ontario, “If you are struggling with your emotions because of an abortion, there is hope. Some women feel relief after an abortion, while other women experience strong negative emotions. Some of these reactions may be immediate. Some occur many years after the abortion.”

In contrast, all five of secular talklines and sexual health centers presented a more nuanced view of women’s experiences after abortion by using language that both acknowledged and validated a range of feelings. As exemplified by one binational secular talkline:

The feelings you have after your abortion may be varied; sadness, relief, anxiety, happiness, grief and guilt. These feelings may change in type and intensity over time. These feelings are normal.

In general, the language used by these organizations was less emotionally charged and focused not on the presumed feelings or experiences of the client but on the non-judgmental support offered by the organization.

[We provide] a talk-line staffed by people trained to listen and help you find peace. We trust you and your choice. We can help by simply listening or providing you with other resources in your area - both religious and non-religious - who can also help you connect with your decision in a way that affirms you.

Outcomes after contacting the service

Many women find that their recovery journeys teach them valuable life lessons that contribute to increased strength of character, wisdom, vision and hope. (CPC website serving women in Central Ontario)

A notable different between CPCs and religiously affiliated talklines on the one hand and

secular talklines and sexual health centres on the other, was the promise of outcome. We found that CPCs in particular used emotionally charged language to entice clients to contact their service. In contrast to the “depression,” “guilt,” and “trauma” that they purport follows an abortion, CPCs routinely advertise their services as offering “hope,” “freedom,” and the ability to “live in color” once more. “*Living in Color* is a post-abortion recovery and healing program. This program offers you help in the process of emerging from the ‘grey zone’ of unresolved loss into a life of colour, freedom, and joy.” Many of these websites also offer testimonials from women who claim to have “recovered” from their abortion experience with the assistance of the service.

I carried my abortion burdens alone for twenty-one years and felt that I could never tell anyone about them, let alone acknowledge my children and have a memorial service! I feel grateful, free, real. This program is awesome! (CPC website serving women in Central Ontario)

Other organization types did not discuss possible outcomes that could come from contacting their service. Rather, their web presence emphasized that the support offered was non-judgmental and confidential. These organizations frequently mentioned that individuals from all backgrounds contact their service and testimonials emphasized the support provided.

People of all ages, genders, races, backgrounds, religious affiliations, and political leanings call [us]. Most of our callers are people who are or have been pregnant, and want to talk about their experiences. We also speak often to partners, parents, friends and loved ones who want to talk about their own feelings and/or how they can support someone in their lives.

DISCUSSION

Previous research has indicated that women in Ontario report difficulty finding and accessing non-directive, non-judgmental, free, and timely post-abortion support services.[15] Yet, when compiling the directory, we were able to identify 41 unique organizations offering

post-abortion support, a number that far exceeds the number of abortion providers in the province. In fact, at the time of the study there were more than three times as many CPCs (n=33) as there are freestanding abortion clinics in the province (n=9).[22] Thus there does not appear to be a shortage of post-abortion support service providers in general; rather there appears to be a shortage of visible non-directive, non-judgmental post-abortion support services. The abundance of CPCs and their dominance online may make it difficult for women to find the few organizations offering client-centred services. Identifying avenues to expand the visibility of existing non-judgmental, non-directive post-abortion support services appears warranted.

A common frustration expressed by reproductive health advocates in dealing with CPCs is that they are not accountable to anyone. Unlike medical clinics, there is no provincial mechanism to regulate these organizations or their services; in fact, in Ontario the majority of CPCs are registered charities.[26] In a 2010 article in the Toronto Star, a spokesperson for the Ontario Ministry of Health and Long-Term Care was quoted as saying, “We don’t fund them [CPCs], so we don’t have a lot of oversight on them. As with these types of things that are sort of outside the ministry purview, it is ‘buyer, beware’ and a matter of people doing a bit of homework.”[27]

However, our investigation revealed that a subset of provincially funded Public Health Units are in fact referring women to these medically inaccurate services. Based on our interactions with these organizations, we do not believe that that these referrals were motivated by anti-abortion sentiments. Rather, we could hear the PHU employee searching the internet and the fact that they then recommended we contact a CPC is likely reflective of the effective advertising techniques employed by crisis pregnancy centres. For those women who are seeking services, there is an expectation that PHUs will provide them with referrals to services that are

both medically accurate and non-judgmental. Indeed, contacting a PHU for a referral for post-abortion support is one of the ways that women attempt to gather unbiased information about available services. That PHUs may then inadvertently refer women to CPCs highlights the lack of visibility of other organizations offering post-abortion support.

Finally, our results suggest that the use of medically inaccurate and shaming language by CPCs and religiously-affiliated talklines represents a method for the anti-abortion movement to stigmatize abortions and pathologize the women who have them. Both the internalized and externalized stigma that continue to surround abortion contribute to the silencing of women's experiences and often drives individuals to seek post-abortion support in the first place. On an individual level, the availability of non-judgmental post-abortion support is important to aid women in processing their experiences. On a societal level, the successful management of complex feelings after abortion may ultimately affect the discourse surrounding abortion services, consequently reducing the stigma and isolation that is linked with these negative outcomes.

Limitations

Our study has both strengths and weaknesses. We evaluated the web presence of post-abortion support providing organizations because previous research has indicated that this is how women are most likely to find information. However, organizations may present themselves and their work differently in different media and thus our analysis does not apply to other modalities of representation. Further, our review did not include services that provide support or lay counselling, in general. There may be additional service delivery points in Ontario that provide free services through talklines or in-person visits that also offer post-abortion support, but do not

advertise that activity. Finally, we did not include pay-for-service providers, including licensed therapists. Our results are confined to those organizations providing free post-abortion support services to women in Ontario.

CONCLUSION

Crisis pregnancy centres represent the majority of organizations in Ontario offering free post-abortion support services. Their web presence often contains shaming and stigmatizing language about abortion that is medically inaccurate. Expanding the visibility of existing organizations that provide non-judgmental, non-directive, client-centred services appears warranted.

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Chapter 5: Toll free but not judgment free: Evaluating post-abortion support services in Ontario

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Abstract

Introduction: Crisis pregnancy centers (CPCs) account for the majority of advertised post-abortion support providers in Ontario, Canada's largest and most populous province. Although the deceptive tactics used by CPCs to dissuade women from seeking abortion care are well documented, their provision of post-abortion support has not been previously explored. Our study aimed to fill this gap.

Methods: In 2014-2015, we conducted a mystery client study with 17 organizations that provide post-abortion support in Ontario. We used a pre-determined character profile and set of prompts to seek services over the phone. Each interaction began with "I'm looking to talk to someone about my abortion." The interactions developed organically and mimicked the experience of a woman seeking post-abortion support. We audio recorded and transcribed all interactions and used both inductive and deductive analytic techniques in our evaluation.

Results: We spoke with three secular and three religiously affiliated talklines, one sexual health center, and ten CPCs offering phone-based support. Although all counselors effectively used active listening techniques such as supportive utterances and attentive silences, the interactions with respondents from the religious talklines and CPCs contained shaming and stigmatizing language and medically inaccurate information. These interactions appear to be premised on the counselors' belief that abortion is traumatic and always requires a grieving process, regardless of the client's expressed feelings and needs.

Conclusions: The expanded provision of post-abortion support by CPCs in Ontario represents a new method for these organizations to pathologize abortion. Our findings suggest their services are judgmental and shaming, thereby contributing to abortion stigma.

Implications

Post-abortion support services appear to be a new frontier by which CPCs are able to stigmatize and pathologize abortion. Increasing awareness of and access to existing non-judgmental, non-directive the post-abortion services appears warranted.

Introduction

Crisis pregnancy centers (CPCs) are organizations that intend to dissuade women from seeking abortion services. Sometimes referred to as “pregnancy resource centers” or “pregnancy support centers,” they advertise themselves as offering free pregnancy tests and counseling services for women experiencing a “crisis pregnancy.” The deceptive tactics used by these organizations have been well-documented by a variety of sources, including researchers [1,2,3], journalists [4,5], and non-profit organizations [6,7]. Common critiques of CPCs include their masking of their anti-abortion political orientation to prospective clients, advertising themselves as medical clinics, providing medically inaccurate information, and using scare tactics such as graphic imagery and videos [1,2,3,6]. However, investigation of CPCs has largely centered on their provision of pregnancy options counseling and little is known about the quality of their other services. Further, despite the growing presence of these organizations across Canada, the majority of research on CPCs has taken place in the US.

Although there are no legal restrictions on abortion in Canada at the federal level, abortion remains politicized. One in three Canadian women will have an abortion over the course of their reproductive lives, making abortion an extremely common experience [8]. In Ontario, Canada’s largest and most populous province, abortion has been deemed a medically necessary service and both hospital- and clinic-based procedures are covered through provincial health insurance [9,10]. At least 30,000 abortions are performed in Ontario each year [11], the majority of which take place in one of 13 freestanding and hospital-based clinics [12]. However, abortion remains surrounded by stigma and shrouded in silence.

Although there is no evidence that first trimester abortion is linked to mental health conditions [13], women may experience a range of emotions and feelings after a termination

[14]. Previous research conducted in Ontario has found that a proportion of women desire non-judgmental post-abortion support following their termination but have difficulty finding and accessing these services [15,16]. Indeed, other research has documented that the overwhelming majority of organizations advertising the provision of free, phone-based post-abortion support in Ontario are CPCs [17]. Informed by this context, our study aimed to investigate the provision of post-abortion support services in Ontario. Specifically, we were interested in examining the language, counseling techniques, and frameworks utilized by these organizations when speaking to those seeking services.

Methods

Using the results from a previous study [17], we identified 37 unique organizations that advertised themselves as offering free post-abortion support services in Ontario and provided a publicly available telephone number. This included six national and bi-national (US-Canada) talklines that exclusively offer phone-based support, two sexual health centers that advertise themselves as offering both in-person and phone-based support, and 29 CPCs; 24 are affiliated with a national Canadian network of pregnancy care centers. Using a mystery client study design, we contacted all 37 organizations between November 2014 and March 2015. The mystery-client methodology involves a researcher visiting a program facility or seeking services in the assumed role of a client in order to evaluate the provision of services, monitor site improvements, and gain a greater understanding of the dynamics of the interaction between client and service provider [18,19]. Previous mystery client studies dedicated to reproductive health issues and services informed our study design [20,21,22].

In order to contact post-abortion support providing organizations, we created a client profile that included personal, relationship, and demographic information as well as language to describe the circumstances and feelings surrounding the mystery client's termination. We based this profile on a composite from our qualitative research documenting women's abortion experiences in Ontario [15], thus enhancing authenticity. We maintained the overall contour of the profile for all interactions but adapted certain details, such as area of residence and location of the abortion providing facility, to match the location of the organizations included in the study.

Data collection

KL initiated each call by saying "I recently had an abortion and I don't have anybody to talk to about it." Using the client profile and list of prompts, she then responded to any questions posed by the service provider. Our standardized prompts allowed our client to consistently describe her feelings, personal circumstances, and relationships. For example, in all interactions our client stated, "I feel very at peace with the actual decision, I just feel like it's been isolating." We provide a synopsis of the profile and our list of prompts on Figure 1. We conducted all interactions in English and allowed the interactions, which averaged 20 minutes, to develop organically over the course of the phone call. We audio-recorded all interactions and KL formally memoed immediately after the encounter to document her experience, reflections, and reactions to the call. She also evaluated each interaction using a checklist, which included criteria related to counseling techniques, tone, and accuracy of information. AF separately listened to each interaction and evaluated each call using the same checklist.

Data analysis

KL transcribed each mystery client interaction in entirety and AF audited a sample of transcripts for accuracy. We managed both the memos and transcripts using ATLAS.ti. We carried out content and thematic analyses of the interactions using both *a priori* (pre-determined) codes and categories based on the study aims and research questions and inductive techniques [23]. The interpretation phase of our analytic plan centered on identifying relationships among themes and concepts and integrating the evaluations from both KL and AF. Through regular discussion, we were able to identify recurrent themes and draw connections between ideas.

Ethical considerations

Our study received approval from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H03-14-07).

Results

Organization characteristics

Of the 37 organizations we contacted, lay counselors from 17 organizations spoke with our client about her abortion experience. Representatives from the other 20 organizations reported that they only provided in-person post-abortion support and encouraged our client to physically visit the center. We ultimately spoke with three secular bi-national (US-Canada) talklines, three national or bi-national religious talklines, one sexual health center, and 10 crisis pregnancy centers. We spoke with crisis pregnancy centers that were physically located in central, southern, and eastern Ontario, which also accounts for where the majority of CPCs are located in the province.

Our analysis revealed significant differences in the client-counselor interactions. These differences largely fell along the lines of organization type and thus we have grouped our findings by secular talklines, religious talklines, and CPCs. For each group of organizations we provide information about the content, tone, language, and medical accuracy of the interactions and discuss major themes that emerged. We use quotes from the interactions to illustrate our findings and have masked all identifying information about both individual counselors and the specific organization.

Interactions with secular talklines

Nobody – nobody – can ever tell you how to feel about anything. I hope you realize that: that the feelings you’re having are very normal and very real and you are entitled them.
(Lay counselor, bi-national secular talkline)

We found there to be considerable consistency among the three bi-national organizations providing post-abortion support to women in Ontario. Talkline counselors effectively used active listening and non-directive counseling techniques, such as supportive utterances, open questions, validating language, and attentive silences. The interactions demonstrated clear respect for client autonomy and the talkline counselors matched our client in mood and tone. The questions asked by the counselors were timely and considered and did not feel unsolicited or invasive. For example, in response to our client expressing uncertainty about her relationship dynamics, the counselor asked, “If you woke up tomorrow and something had shifted, and your problem was fixed - how would you know? What would have changed?” At the closing of the interactions, counselors from all three talklines worked with our client to come up with an individualized strategy to address the issues she had raised during the call, including journaling and brainstorming ways to start a conversation with her partner. Our interaction with the one sexual

health center included in the study was consistent with these overall dynamics. Although counselors from all four organizations encouraged our client to call again, if needed, none pressured her to seek therapy, enroll in a program, and/or visit a physical location.

We did observe some differences between the talklines. Notably not all counselors from the bi-national talklines were equally familiar with Ontario or abortion care in the province. However, the overarching dynamics were similar and consistent with standard lay counseling techniques [23, 24].

Interactions with religiously-affiliated phone lines

[This] is about us supporting you and your child. 'Cause there's a child. And your child is in Heaven, I'm sure. (Lay counselor, bi-national religious talkline)

All three of the religiously-affiliated talklines clearly identify themselves as faith-based and actively encourage people of all backgrounds and beliefs to contact them for post-abortion support. Counselors from all three talklines appeared to use active listening, attentive silences, and supportive utterances. However, the language used by counselors from two of the talklines demonstrates a lack of reflective listening or validation. As illustrated by the above quote, counselors from two of the talklines repeatedly used words like “child” and “baby” to describe the fetus or pregnancy, even though our client never used those terms. These same counselors pathologized our client's abortion experience; in one case the counselor “diagnosed” our client and her partner with “post-abortion stress disorder” less than three minutes into the call.

Because you're going to start reading [the website] going, “Oh my gosh, yes, I've had a terrible dream.” Or, “Yes, I've been crying.” Or “I can't stand that noise”, or “I can't stand in parks with a child”. You know, all different things happen. And it's all part of a stress disorder that you're going through.

These interactions were also infused with medical inaccuracies. As one counselor stated in response to our client describing her pregnancy as unplanned and surprising, “So many women are victimized by contraception and the lie that it prevents pregnancy.”

Our interaction with one of these organizations was strikingly different. The counselor in that interaction did not pathologize our client and used reflective language throughout. This organization’s counselor exhibited non-directive, non-judgmental techniques more akin to those employed by counselors at the secular bi-national talklines. However, none of these interactions included individualized strategies for engaging in self-care or addressing issues raised during the call. Rather, counselors from all three organizations referred our client to services, websites, and/or books that contain shaming language about abortion.

Interactions with crisis pregnancy centers

The reality is, the way women are wired, we’re not wired to get rid of our offspring. It’s just not a natural thing to do. (Lay counselor, CPC in central Ontario)

We spoke with counselors from 10 CPCs across Ontario. All of these counselors indicated that they preferred to provide post-abortion support in-person and encouraged our client to visit the facility. In most cases, the counselor portrayed the agreement to speak with our client on the phone as a compromise, with the expectation that she would later visit the center in-person. One CPC disclosed its religious affiliation to our client at the beginning of the interaction. However, no other counselors identified their centers as faith-based, even though most of the counselors referenced God and/or Christian beliefs during the call itself. Indeed, several counselors continued to make religious references even after our client stated that she did not ascribe to a particular belief system or identify as Christian.

Consistent with the interactions at other organization types, CPC counselors used active listening techniques, such as supportive utterances. However, these interactions included an abundance of shaming and stigmatizing language couched in validating and supportive language. For example, after our client mentioned that she did not feel like her partner understood how she was feeling, the counselor from a CPC in the southern region of Ontario responded by saying “I can tell you, in all my years of doing this...I’ve never, ever had a one woman say to me that [the abortion] was the best thing they’ve ever done in their life. That they’re glad they did it.” Similar to the religiously-affiliated talklines, counselors repeatedly used “child” and “baby” irrespective of the terms used by our client.

Although they sometimes asked considered questions, all CPC counselors consistently asked unsolicited, invasive, and personal questions that were not related to the tone or content of the interaction. Often these questions related to physical aspects of the abortion procedure, if our client had experienced complications, and whether or not our client was experiencing “flashbacks.” Counselors repeatedly made non-evidence based statements about the physical and mental health sequelae of abortion. As one counselor from a CPC located in central Ontario stated, “An abortion is a traumatic event and many women continue to struggle with the fall out for months or years...If you have several of these symptoms [previously described as depression, anxiety, and self-harm], it does have a name. It’s called post-abortion stress. PAS. Or post-abortion syndrome.”

In stark contrast to counselors at other organization types, CPC counselors routinely offered considerable personal information about themselves – including information about their pregnancy experiences. One lay counselor from southern Ontario said, “When I was very young,

I chose abortion. And I thought I was okay. And it turned out...I wasn't in time." In fully half of the cases, the counselor actually spoke more during the recorded interaction than our client.

Based on the congruence between the different calls with CPC counselors, we identified four assumptions that appear to underlie the client-counselor interaction: 1) Abortion is a traumatic birth loss; 2) Abortion requires a grieving process; 3) Abortion leads to post-abortion stress; and 4) Recovery requires extensive in-person contact. Notably, CPC counselors repeatedly explained that these dynamics applied to all abortion experiences, even if our client did not perceive her own experience in this way. For example, one CPC counselor from southern Ontario explained, "There is a loss component to an abortion, even if that's something that you decided and you're still okay with that decision and what not. Because you go in pregnant, and you come out not pregnant. And that's a pregnancy loss." Another CPC counselor from a facility located in central Ontario explained to our client, "And also recognizing that you are going through a grief process. I mean whether somebody recognizes that or not, it is a grief process."

Consistent with the assumption that "recovery" from abortion requires considerable effort, all CPC counselors recommended that our client participate in an 8-10 week program called *Living in Color*. Counselors explained that this type of intensive work was necessary because the emotional toll of abortion was both long-lasting and inherent to being a woman. As explained by one counselor at a facility in central Ontario, "There's certain timeframes that you might find you're going to be a little bit more emotional than normal...The time when the baby might have been born...The anniversary date of the abortion procedure. All of those dates become embedded in our memory and our minds as a woman." The CPC counselors all asked for personal information from our client – such as contact information – in order to follow-up.

Discussion

Kimport, Perrucci and Weitz have argued that the silence and stigma surrounding abortion mean women have few spaces and opportunities to discuss and process their experiences and thus abortion talklines are valuable for callers [26]. Major and colleagues found that women who discussed their abortion with a significant other and perceived that person to be less than completely supportive of their decision were actually more distressed post-abortion than women who kept their abortion a secret [27]. Thus it is critical that post-abortion support resources be non-politicized, non-judgmental, and non-directive.

The results of our evaluation of telephone-based post-abortion support services in Ontario are concerning. Counselors from two of the three religiously-affiliated talklines and all CPCs employed shaming and judgmental language and exhibited directive “counseling” techniques. These lay counselors routinely provided medically inaccurate information, pathologized our client’s abortion experience, and in several cases went so far as to diagnose our client with a mental health disorder. Counselors at CPCs in particular insisted that our client’s single first trimester abortion would lead to depression, anxiety, sleep disorders, and substance abuse, in direct conflict with the scientific literature [28,29,30] and the American Psychological Association [13].

During the course of this study, we were able to obtain a copy of the 189 page guidebook for the *Living in Color* program [31]. The stated goal of the 8-10 week program is to support “post-abortion recovery.” The content of the book confirmed our findings regarding the assumptions underpinning the services offered by CPCs. The *Living in Color* program presumes abortion is a traumatic experience and the book’s introduction informs clients that “An abortion is an intense and painful personal experience and that dealing with it is a challenging journey.”

That all CPCs referred our client to an intensive in-person recovery program, even though she exhibited no acute distress and repeatedly indicated that although she felt isolated she did not regret her decision, signals the existence of a larger agenda.

However, our study also suggests that there are organizations that offer high quality, non-judgmental, client-centered post-abortion support services in Ontario. Given that there is a documented demand for these services in the province, it is essential that these services are advertised and promoted to women, both online and through reputable referees such as abortion providing clinics and public health units. Resources to help women identify crisis pregnancy centers and document the tactics they use may also be warranted.

Limitations

One investigator (KL) conducted all of the mystery client calls. Although this increased consistency between the interactions with different service providers, the positionality of the individual researcher undoubtedly impacted the client-counselor dynamics. In addition, we knew the type of organization being contacted at the time of the interaction. By using a standardized profile with consistent prompts we aimed to minimize this potential bias. Further, through formal memos, independent evaluation of the interactions by a second investigator, and study team discussions we believe we were able to understand this impact and increase the credibility and trustworthiness of this study. Further, despite contacting all of the 37 identified organizations, not all of the providers of post-abortion support agreed to speak with our client. Thus we are unable to state with confidence that our findings apply to those organizations that only provide in-person services; in-person interactions may reflect different dynamics than those over the phone.

Conclusion

Our findings suggest that post-abortion support services may be a new frontier by which CPCs are able to stigmatize abortion. Women seeking post-abortion support should be made aware of the underlying assumptions in services provided by CPCs. Increasing awareness of and access to existing non-judgmental, non-directive the post-abortion services appears warranted.

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Chapter 6: Discussion

This chapter begins with integration and triangulation of the results from the three articles included in this thesis. I then situate the findings within the context of reproductive justice. Next, I consider and reflect on my positionality as a researcher and my experiences conducting this study. The chapter then moves on to include a discussion of the significance and implications and future directions of this work. The final chapter then closes with a discussion of the strengths and limitations of this thesis as well as conclusory statements.

6.1 Integration of results

This project aimed to conduct an in-depth, rigorous investigation of post-abortion support services in Ontario. By analysing women's abortion and post-abortion support experiences, creating a directory of services, analysing the web presence of providers, and then conducting mystery client calls at a subset of these organizations, a clear story emerged about the landscape of post-abortion support in the province. Women's reported experiences suggest that the need for and interest in free, non-judgmental, non-directive, accessible post-abortion is considerable. But the results of our three part study highlight three main findings: 1) Crisis pregnancy centers and faith-based phone lines account for the vast majority of organizations offering post-abortion support in Ontario; 2) It is significantly more challenging to find resources and services from secular phone lines and sexual health centers; and 3) Crisis pregnancy centers and faith-based phone lines use shaming and stigmatizing language to pathologize women's abortion experiences.

6.1.1 Organizations offering services

As discussed in the first article (Chapter 3), the Ontario Abortion Study found that following a termination, there are a proportion of women who want to access non-judgmental post-abortion support. However, the majority of women reported being unable to find and access such services. In compiling the directory of organizations offering this service in the province, it became clear that there are in fact significantly more providers of post-abortion support than there are providers of abortion care. While these two findings may at first appear to be contradictory, an oversaturation of post-abortion support services offered by CPCs functions to make finding services offered by other types of organizations very challenging. As a result, crisis pregnancy centers have monopolized the provision of post-abortion support in Ontario. This is in part due to the sheer number of CPCs across the province, but it is also because CPCs are actively working to advertise themselves as providers of this service. In contrast, many well-known sexual health centers do not specifically discuss post-abortion support as a part of their web presence. As a result, women seeking services may not think to contact these organizations.

The process of contacting Public Health Units across Ontario and asking for a referral to post-abortion support yielded both inconsistent and concerning results. Particularly in more rural areas of the province, PHUs may be the only health care provider in the area. Although the situation has improved in recent years, a large number of Ontario residents do not have a family doctor (63). Consequently, for many individuals, PHUs are often the only available point of contact for health care services and referrals. Of particular note were the PHUs that recommended I contact a crisis pregnancy center. I do not believe that these referrals were motivated by anti-abortion sentiments; rather, I could often hear the PHU employee searching the internet as I was on the phone with them. That they then recommended I contact a CPC is reflective of the unfortunate success of the advertising techniques employed by crisis pregnancy

centers. Services offered at CPCs consistently rank first in search results and their websites often claim to offer non-judgmental services.

6.1.2 The provision of post-abortion support services

The mystery client component of this study yielded consistent results across organization type. I had originally planned to carry out 40 full length interactions using two distinct client profiles but only ended up being able to complete 17 calls using the one client profile. However, this in no way affected saturation. Thematic saturation refers to the point at which no new information or themes are observed within the data (64, 65).

As outlined in Article 3, I was able to identify several key assumptions made by counselors at CPCs and faith-based phone lines. These assumptions led to the provision of judgmental services. In contrast, the counselors at secular talklines and the sexual health center did not insert their own views and opinions into the interactions. In addition, when reviewing the transcripts from this component of the study, I noticed that in interactions with CPCs and religiously affiliated talklines, the amount of time that the counselors spent talking was equal to, or sometimes more than, the client. Significant portions of these interactions were devoted to various forms of counselor monologue. In contrast, in the interactions with secular phone lines and the sexual health center, the counsellors spoke very little and instead offered reassuring and supportive utterances or appropriate probes to elicit further reflection from the client.

I ended each call with CPCs knowing a fair amount of personal information about the counsellor that I had spoken with. For example, the counselors often disclosed to me their relationship status, pregnancy history, and information about their family and family dynamics.

This was a clear distinction between the interactions I had with counsellors at other organizations as I ended the calls unaware about any of the counselor's personal information.

These trends are a further indication that the care provided by crisis pregnancy centers and faith-based phone lines are not client-centered. Rather, the interactions are counselor-centered and represent an opportunity to impose the counselor's personal beliefs about abortion onto the client, rather than facilitate client coping and support.

6.1.3 *Living in Color program*

All of the CPCs that I contacted made reference to their "post-abortion recovery program" called *Living in Color*. The program can be completed in either a group format or individually with a counsellor and requires an 8 to 10 week commitment from the client. Each CPC strongly encouraged me to visit the center and take part in the program; those CPCs that refused to offer support on the phone did so because, as they explained, they wanted me to attend the center in person and complete the program.

The assumption that it is appropriate to refer every client, regardless of the way she describes her experiences, to an intensive, multi-week program clearly represents a way to pathologize abortion. This response is not reflective of individual client needs and is instead both unsolicited and predatory. For those working within the health care profession, there is frequent discussion of practitioner-patient or counsellor-client relationship dynamics (66). That is, there is an acknowledgement that health care providers are in a position of power with their patients (67). Even though the counsellors that I spoke with were all peer or lay counsellors, the power dynamic inherent in a client-counsellor interaction was still present. Pressuring a client to visit a

center in person, even after she has described an inflexible schedule and lack of access to a vehicle, can be viewed as an attempt to maximize the counsellor's influence in these interactions.

During the course of the study, I received a mailed copy of the *Living in Color* guidebook from a CPC. The book is 189 pages and divided into eight chapters. Underlying the book are many of the same assumptions that became apparent during the mystery client calls. Namely, there is a belief that abortion is always a traumatic experience and always requires a grieving process. As an example, one chapter calls for participants in the program to create a memory box (68). In the box, the participant is told to include:

A card welcoming a new baby; a poem, quote, or scripture verse that you would choose to include in a baptism or baby dedication service; An item or small piece of clothing for your baby; A sympathy card for a baby who has died; A poem, quote, or scripture verse that you would choose to include in a memorial service for your baby; A memorial token for your baby (65, p151).

After the creation of the memory box, the participant is instructed to have a balloon ceremony.

The balloon ceremony is a type of “memorial service for your child” (68, p154).

Living in Color is a Christian faith-based program, and discloses this framework on the first page in the guidebook. However, on their websites, few CPCs disclose or discuss a religious affiliation. Rather, they emphasize the support that they offer to women of all backgrounds before, during, and after their experience with a “crisis pregnancy”. Further, when I called CPCs, only one organization discussed with me the center's faith base at the beginning of the interaction. This is yet another example of how the services offered at CPCs are not client-centered, but rather counselor-centered.

6.1.4 *Triangulation of results*

The methods utilized in this project were selected for the purpose of later being able to triangulate the results. Triangulation refers to the use of multiple methods to study the same phenomena and this approach is used to examine complementarity, congruence, and dissonance between findings (51). I had initially planned to examine Phases 2 and 3 of this project in conjunction. However, the addition of the *Living in Color* guidebook allowed for a third component to analyse the services offered specifically at crisis pregnancy centers.

The analysis of the separate components of this study demonstrated high levels of congruence. Indeed, the themes identified in examining the online presence of providers of post-abortion support often overlapped with the underlying counsellor assumptions (or lack thereof) that I identified during the mystery client calls. With regards to CPCs, these themes were again present in the *Living in Color* guidebook. The results of all components of this study clearly documented the shaming, stigmatizing, and judgmental frameworks of crisis pregnancy centers offering post-abortion support services.

6.2 Incorporating reproductive justice into post-abortion support

Despite increasing efforts in recent years to bring attention to the need for non-judgmental post-abortion support, the issue remains somewhat controversial and has yet to be routinely incorporated into abortion care across the US and Canada (Chapter 3, this thesis, 28, 32). Further, there is little research on the topic and women's voices are notably absent from the literature that does exist. There are a number of reasons for why this could be the case. Namely, both abortion and, as described in Chapter 1 of this thesis, the mental health outcomes that follow a termination remain politicized issues. The acknowledgment that some individuals want support after an abortion can easily be re-framed in a way to promote anti-abortion sentiments.

That is, it may be perceived that women seeking post-abortion support are doing so because abortion in itself is a traumatic or harmful procedure, rather than the fact that societal stigma limits their opportunities to share and discuss their experiences. As a result, campaigns on both sides of the abortion debate have tended to discuss the feelings that women can experience after an abortion in a polarized way rather than on a spectrum. Indeed, these conversations are often limited to regret and relief (28). Yet, women can experience a wide variety of circumstances that lead them to an abortion, and can also experience a complex range of feelings afterwards.

Unfortunately, despite efforts by a growing number of reproductive health advocates to bring the issue of post-abortion support to the forefront, crisis pregnancy centers and faith-based phone lines have monopolized the service through a combination of targeted strategies. As documented by this thesis, in Ontario the anti-abortion movement appears to be dominating the dialogue on post-abortion support. However, accessible post-abortion support that is both non-judgmental and client-centered is an issue of reproductive justice (RJ). Instead of framing a desire for post-abortion support as a form of concession, this service should be discussed as an integral component of holistic abortion care and reproductive justice.

6.2.1 A brief history of reproductive justice

Although the term reproductive justice was not officially coined until 1994, the RJ movement has a long history that is informed by years of civil rights violations and abuses (69, 70). For example, the documented histories of forced sterilization and contraceptive coercion are seen as directly contributing to the present-day reproductive justice movement (71, 72). RJ is a movement that has largely been led by women of color and aims to merge social justice issues with reproductive health (71).

As another prominent issue that contributed to the development of the reproductive justice movement, in the 1980s, the dialogue of choice within the abortion debate sparked controversy. Many women argued that premising the movement on “choice” was both insufficient and a misnomer, as there were circumstances in women’s lives and realities that meant they could not make a choice in the first place (73). RJ activists argued that the reproductive rights movement had thus far been preoccupied with the experiences of upper and middle class white women, and advocated for an intersectional approach. Intersectionality acknowledges the interactions between different forms of oppression and discrimination (74). It argues that there are multiple identity categories that each of us belong to, such as gender, race, ability, sexual orientation and class, that interact on multiple levels and cannot be pulled apart and examined separately (75). Thus, RJ goes beyond a rights framework and instead aims to address the historical, social, and economic factors that contribute to issues of women’s oppression (70). Today, reproductive justice is defined as “the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women’s human rights” (76).¹

6.2.2 Using reproductive justice to advocate for non-judgmental support

As demonstrated by its definition, reproductive justice is not a singular movement. It encompasses a wide variety of issues, including contraception, abortion, child care, infertility treatments, sexual violence and more. Using a reproductive justice lens to examine issues of abortion stigma, we can acknowledge that individuals have complex identities which can affect

¹ Despite the use of the word “women” in the definition of RJ, the reproductive justice movement is evolving beyond the gender binary. It is making strides to incorporate gender-queer and LGBTQ individuals into their initiatives by acknowledging the unique experiences and oppressions faced by LGBTQ individuals and communities.

their personal relationship with this procedure. Personal circumstances also influence access to services, who a woman chooses to or is forced to disclose her pregnancy status to, and the network of social support surrounding her decision to terminate (70). All of these factors also directly influence whether a woman chooses to seek or not seek post-abortion support services following a termination.

Given RJ's focus on not just physical health, but also mental, spiritual, and social wellbeing, the justification for non-judgmental and client-centered post-abortion support seems obvious when approached from this framework. We need to recognize that routinely incorporating reputable post-abortion support into abortion care is not detrimental to a movement advocating for access to abortion services. Rather, it is acknowledging that of the more than 90,000 Canadian women who have an abortion each year (77), it is possible for them to have varying experiences and feelings surrounding their decision. Ensuring that for those women who want it, access to timely, non-judgmental post-abortion support is available is an issue of reproductive justice.

6.3 Positionality and experiences of the researcher

Two important concepts related to qualitative research are those are positionality and reflexivity. Positionality refers to the identity, experiences, and perceptions of the researcher (78); in other words, what might affect the subjectivity of the researcher in how he or she interprets and observes his or her own experience? Reflexivity refers to an active process of self-scrutiny which involves the researcher acknowledging his or her own biases and perceptions and reflecting on how these influence the research process (79).

The methods utilized in this study were selected in order to mimic, as closely as possible, the experience of a woman seeking post-abortion support. I went through the process of searching for services, reading online about the services offered at the organizations that I was able to identify, and finally contacting an organization to discuss my experience. However, my position as a researcher (rather than a client seeking services) creates some inherent differences. As a researcher investigating a phenomenon, I was a step removed from the process. When contacting the services, I was not in a vulnerable position, and consequently in my role, I was perhaps more actively attuned to the language and frameworks used by the organizations. As well, I was concerned with the broader implications of each interaction. For example, throughout the process of data collection, I reflected on how the advertisements and services offered by individual organizations may either contribute to or refute notions of abortion stigma. Finally, as a researcher I am expected to view my experiences through a critical lens. This is not to say that an individual seeking services cannot or will not be critical of an organization's online presence or provision of services, but rather that it is not necessarily required for someone in the role of a client.

Still, I felt personally affected by the interactions in the role of a mystery client. I was using a pre-determined client profile and list of prompts during each call, both of which are intended to reduce the influence of my own positionality. However, each call still required that I put myself into the position of the client and use my own words to describe experiences. In order to be an effective mystery client, I expressed the client's feelings in ways that I am familiar with and would do so outside of this context. I also attempted to relate varying points in the client profile to my own life in order to increase believability in and authenticity of the interaction.

The interactions with different organizations had varying effects on my mood and demeanor, which I recorded in my memos following each call and also discussed with my supervisor throughout the process. I noted that after calls with the secular phone lines and the sexual health center, I felt positive and optimistic. Even though I was discussing issues determined by the client profile, the counsellors were so validating of my emotions, choices, and self that it translated to positive feelings about my own life.

In contrast, the calls with CPCs and faith-based phone lines left me feeling emotionally exhausted. I often felt like my words were being taken out of context and used against me to promote an agenda that I did not personally agree with. I also struggled with the power dynamic of the client-counselor interaction. I found it difficult to determine how much to push back with the counselor when she made statements that I disagreed with. It was stressful to have a counselor assert that they understood what I was trying to say, and then reframe my statement in a way that was opposite of what I had said. I believe that the effects these interactions had on me as a researcher illustrates the importance of post-abortion support services being client-centered and non-judgmental.

6.4 Significance and implications

This study represents the only rigorous, in-depth investigation of post-abortion support services in Ontario to date. It is also the only comprehensive investigation of crisis pregnancy centers in the province. Although there is an abundance of anecdotal evidence and a growing body of academic research related to the deceptive behaviors of CPCs, the vast majority of this information is US based and focuses on the provision of pregnancy options counseling (27, 37-39).

The results of this study indicate that crisis pregnancy centers in Ontario have a monopoly on post-abortion support services, and also that this represents a new way for these organizations to shame and stigmatize women's abortion experiences. The information collected as a part of this project has already been integral in efforts to expand the provision of non-judgmental post-abortion support services in the province. In 2014, my supervisor and I applied for and received a one-time, one year grant from Women's Xchange at the Women's College Research Institute. Based on the demonstrated need for post-abortion support in the province, we received \$15,000 for a small scale community initiated project, and partnered with Backline to increase awareness of their services in Ontario. Backline is a toll-free phone line that is available to both Canadian and US callers, and offers client-centered, non-judgmental support surrounding all pregnancy options, including abortion, adoption, and parenting, at any point in the process. As a part of this project, I prepared an Ontario-focused training module for Backline volunteers. Although advertising initiatives for this project are still underway, Backline has already reported an increase in callers from both Ontario and Canada.

6.5 Future directions

I plan to distribute the findings from this study across multiple mediums, including peer-reviewed journals, academic conferences, and also blogs, websites, and specifically feminist and/or reproductive health oriented news outlets. As this project was conceptualized as action research, it is especially important to disseminate the findings in a way that will be socially relevant and can be used for actionable change. As such, we cannot limit dissemination strategies to purely academic streams as these remain largely inaccessible to both those seeking services and front-line workers. Rather, by distributing this information through the mainstream media,

we can begin to limit the reach of CPCs. Given the deceptive tactics that were found on the websites of CPCs and religiously affiliated talklines, I also plan to create a reference sheet for women to help them identify these organizations. A documented strategy employed by CPCs is to mimic the appearance of abortion clinics and/or sexual health centers (27). Consequently, compiling a list of key words and phrases to help individuals differentiate between reputable service providers and those offering judgmental support will serve as a valuable resource.

It is also important to share the results of this study with Public Health Units in Ontario. Given the prominent role of PHUs in many communities around the province for those seeking health care services, it is important to increase their awareness about the availability of non-judgmental post-abortion support. We will provide PHUs with reputable organizations that they can refer their clients to so as to avoid any more health units referring women or their partners to CPCs. As stipulated by our REB approval, we will also be producing a short report with the results from this study for all of the organizations that offer post-abortion support in Ontario.

Finally, another actionable strategy for change is to share the findings of this thesis with abortion clinics in Ontario. Presently, more than half of all the terminations that occur annually take place in a clinic setting (77, 80). When speaking with women about their abortion experiences as part of the Ontario Abortion Study, many reported that they received a take home package from the clinic which contained information about the physical recovery process from the procedure. If clinics were to routinely incorporate information about reputable services offering post-abortion support into their materials, it would serve as another way to decrease the reach of CPCs.

Future research should be carried out to investigate the availability, accessibility, and structuring of post-abortion support services in other settings, including across Canada and the

United States. This study reveals that the provision of post-abortion support is an important tactic being implemented by CPCs and the anti-abortion movement in Ontario. Understanding the larger scope of this phenomenon is key to determining ways to circumvent the influence of CPCs.

6.6 Strengths and limitations

This study has a number of both strengths and limitations. Namely, in creating the directory of post-abortion support services in the province, we cannot be certain that this is an exhaustive list of organizations offering the service. We utilized searching strategies that were specifically identified by women when they were seeking post-abortion support (Chapter 3, this thesis), but this does not guarantee that we were able to identify all service providers in the province. Further, organizations may present themselves and their work differently in different media and thus our analysis does not apply to other modalities of representation. Our review also did not include services that provide support or lay counseling, in general. There may be additional service delivery points in Ontario that provide free services through talklines or in-person visits that also offer post-abortion support, but do not advertise that activity. Finally, we did not include pay-for-service providers, including licensed therapists. Our results are confined to those organizations providing free post-abortion support services to women in Ontario.

I conducted all of the mystery client calls which can be considered both a strength and limitation of the study. As I was the only one speaking with organizations, this increased consistency between interactions. At the same time, as I was the only one making the calls, my positionality as a researcher undoubtedly affected the client-counsellor interactions. However, through the use of formal memos, independent evaluation of the calls by my supervisor, and

study team discussion, we believe that we were able to understand the impact of this and increase the credibility and trustworthiness of this study. Further, by rehearsing the calls with former talkline volunteers, this created authenticity for both the client profile and interactions.

A further limitation of the study is that despite contacting all of the identified organizations, not all of the providers of post-abortion support agreed to speak with me on the phone. Thus we are unable to state with confidence if these findings are the same for those facilities that provide in-person services. However, by using different methods to examine the provision of post-abortion support services, this is another mechanism through which we were able to increase the credibility and trustworthiness of this study. The congruence between interactions was significant. As well, even though we were unable to assess organizations that only offer in-person services, those organizations referred me to the same Living in Color program that I was referred to by those that agreed to speak with me on the phone.

Finally, qualitative methods provide an excellent mechanism to examine previously unexplored phenomena. However, the methods utilized in this thesis are not intended to yield representative and generalizable results. The congruence both within phases of the project and across different components of the study give us confidence that the themes we identified are significant. Still, we are unable to assess the degree to which these experiences represent broader trends.

6.7 Conclusions

During the course of their reproductive lives, one in three Canadian women will have an abortion (80). The absence of federal restrictions on abortion in Canada has resulted in Canada having one of the most liberal laws in the world with respect to abortion (81). Yet the issue

remains contentious. Indeed, the stigma that remains in the Canadian social and political climate works to silence women's voices and leaves them with few opportunities to discuss their experiences.

The findings from our exploration of women's abortion experiences (Chapter 3, this thesis) inspired this project. This study served as the first in-depth investigation of post-abortion support services in Ontario and revealed a number of key findings. Namely, the majority of organizations promoting themselves as offering this service in the province are crisis pregnancy centers and faith-based phone lines. Even though these services are advertised as non-judgmental, the services offered by these organizations work to both shame and stigmatize women's abortion experiences and are counselor-centered rather than client-centered. The expanded and unethical provision of post-abortion support by CPCs represents a new strategy for these organizations to pathologize abortion and contribute to abortion stigma.

However, there are a number of organizations that offer high quality, non-judgmental support services in the province. Unfortunately, these services are challenging to find, which is in part due to the large number of CPCs that are actively promoting their post-abortion "recovery programs". It is essential that these organizations increase their visibility online and work with other services that are frequently points of contact for women seeking referrals, such as Public Health Units and abortion clinics, to promote their services.

On an individual level, the availability of non-judgmental post-abortion support is important to aid women in coping with the internalized and externalized stigma surrounding their experiences. On a societal level, the successful management of complex feelings after abortion may ultimately affect the discourse surrounding abortion services, consequently reducing the stigma and isolation that is linked with these negative outcomes.

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Appendix A: Client profile

Name: Lauren

Age: 24

Educational background: Completed a college program in Travel and Tourism

Current occupation: Full-time cashier at Walmart

Relationship history and status: She has been dating her boyfriend Brian for 3 years, and they have been living together for 1 year. Overall she is quite happy with this relationship, but feels that the abortion was challenging for both of them.

Living arrangements: She lives with her boyfriend and cat in a one-bedroom apartment. She moved to [city] about a year ago with her boyfriend. They relocated together for his job.

Family: Her parents live in Saskatchewan, where she is originally from. She is on good terms with her parents but does not have the type of relationship where they have many personal/emotional discussions. Her sister, Emily, whom she is very close with, lives in Nova Scotia and is attending Dalhousie University for a PhD program in cognitive neuroscience. She has a hard time being away from her sister and feels that Emily is often too busy to stay in touch as much as she would like.

Friends: Lauren has had a hard time making friends since moving to [city]. Most of her friends are still in Saskatchewan and Lauren describes herself as quite shy. She has made one close friend named Paula through working at Walmart, but Lauren feels that Paula is emotionally unavailable as of late due to her own personal problems with family and finances.

Circumstances surrounding pregnancy: Lauren was using OCPs and so thought that she couldn't get pregnant. Her periods have always been irregular, even on the pill, so she has never tracked her period or paid much attention to it. Her period was late, but she is not sure how late it was – it just occurred to her one day that she probably should have had a period. Her boyfriend urged her to take a pregnancy test, which she did at home after purchasing several tests from Dollarama. All of the tests came back positive. Lauren felt shocked and overwhelmed; she and Brian initially wanted to parent together and had several discussions about this.

Other options considered: She considered continuing with the pregnancy and parenting because she is in a relationship that she considers to be both stable and long-term. Ultimately, she would like to parent with Brian in the future. Brian is a few years older than Lauren and wanted to continue with the pregnancy, but was ultimately supportive of her decision to terminate.

Reasons to terminate pregnancy: Lack of financial stability, wanting to find more fulfilling work, feeling too young to parent, wanting to travel

Feelings surrounding decision to terminate: She is comfortable with her decision to have an abortion but feels that it has put a strain on her relationship with Brian. Lauren also feels that it has been an isolating experience; she doesn't feel comfortable discussing it with her parents and her sister hasn't been able to be there as much as Lauren would like her to be.

Details of abortion: Aspiration abortion, performed at 11 weeks' gestation about 3 months ago. She was about 8 weeks along when she confirmed her pregnancy at home, took a week to consider her options, and then had to wait 2 weeks for an appointment. She has had no physical complications following the termination.

Appendix B: List of prompts

1. I feel very at peace with the actual decision, I just feel like it's been an isolating experience.
2. I wish that there were more people that I could talk to about this.
3. I know my boyfriend loves me and supports me, but I feel like he doesn't understand what I'm feeling.
4. I feel sad because I would ultimately really like to parent with him, just not now.
5. I know that in time everything will be okay, I'm just having a hard time with it now.



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Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Angel	Foster	Health Sciences / Others	Principal Investigator

File Number: H08-12-08

Type of Project: Professor

Title: Safe, legal and hard to get: Documenting geographic disparities in abortion access in Ontario

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
11/05/2012	11/04/2013	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
<http://www.research.uottawa.ca/ethics/forms.html>

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
<http://www.research.uottawa.ca/ethics/forms.html>

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Riana Marcotte
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB



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University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

REB Appeal Committee

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Angel	Foster	Health Sciences / Others	Supervisor
Kathryn	LaRoche	Health Sciences / Others	Student Researcher

File Number: H03-14-07

Type of Project: Master's Thesis

Title: The Availability, Accessibility, and Structuring of Post-Abortion Support Services in Ontario

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
08/06/2014	08/05/2015	Ia

Special Conditions / Comments:

N/A

**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Catherine Paquet
Director
For Raphael Saginur, Chair of the REB Appeal Committee